1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02020

CERTIFICATE OF DEATH

02015

1. **PLACE OF DEATH**
   a. COUNTY: Carroll — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
   c. LENGTH OF STAY IN 1b: 1yr.1mo.12dys.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Springfield State Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Montgomery
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Monrovia
   d. STREET ADDRESS: Moxley Road
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First HOMER — Middle (NMN) — Last ALLNUTT

4. **DATE OF DEATH**: Month FEBRUARY — Day 20 — Year 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 8-19-1882

9. AGE (In years last birthday): 84 yrs.
   IF UNDER 1 YEAR: Months — Days
   IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Well Driller

10b. KIND OF BUSINESS OR INDUSTRY: well drilling

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Aden Allnutt

14. MOTHER'S MAIDEN NAME: Jemie Duvall

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 218-10-8491

17. **INFORMANT** Address: Records, Springfield State Hospital

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: Days
   491X
   DUE TO (b):
   Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
   DUE TO (c):

   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): CBS assoc. with cerebral arteriosclerosis, with psychotic reaction Arteriosclerotic cardiovascular disease

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospitol) attended the deceased from 1-5-66, 19__ to 2-20-67, 19__, that (I) (we) last saw the deceased alive on 2-20-67, 19__, and that death occurred at 7:15 A.M., from causes and on the date stated above.

22a. SIGNATURE: Octavio A Ruiz M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 2-20-67

22c. PHYSICIAN'S NAME (Type): Octavio A. Ruiz, M. D.

22d. ADDRESS: Springfield State Hospital Sykesville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2-22-67

23c. NAME OF CEMETERY OR CREMATORY: Montgomery Methodist

23d. LOCATION (City or Town) (County) (State): Claggettsville Mont. Md.

24. FUNERAL DIRECTOR: Francis H. Barber — ADDRESS: Laytonsville, Md.

25a. REC'D BY REGISTRAR DATE: FEB 24 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02021 02016

1 (M)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corparate limits, write RURAL and give nearest town): Rural--Sykesville
c. LENGTH OF STAY IN 1b: 8mo. 4days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Frederick
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Brunswick
d. STREET ADDRESS: 503 Sixth Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Delena — Middle: Pearl — Last: Ambrose

4. DATE OF DEATH: Month: 2 — Day: 27 — Year: 19 67

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: 1/15/85

9. AGE (In years last birthday): 82 yrs.

IF UNDER 1 YEAR: Months: ____ Days: ____
IF UNDER 24 HRS.: Hours: ____ Min.: ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): West Virginia

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Samuel Bohrer

14. MOTHER'S MAIDEN NAME: Eliza Hoyle

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 214-54-0537

17. INFORMANT Address: Springfield Hospital records, Sykesville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Septicemia — INTERVAL BETWEEN ONSET AND DEATH: days
DUE TO
(b): decubitus ulcers — days
DUE TO
(c):
715X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Chronic brain syndrome associated with circulatory disturbance with psychotic reaction.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that ☒ (this hospital) attended the deceased from 6/23/, 1966, to 2/27/, 19 67, that ☒ (we) last saw the deceased alive on 2/27/ 1967, and that death occurred at 10:45 a.m., from causes and on the date stated above.

22a. SIGNATURE: Naci N. Buyukunsal M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 2/27/67

22c. PHYSICIAN'S NAME (Type): Naci N. Buyukunsal, M. D.

22d. ADDRESS: Springfield State Hospital Sykesville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 3-2-67

23c. NAME OF CEMETERY OR CREMATORY: PARK HEIGHTS

23d. LOCATION (City or Town) (County) (State): BRUNSWICK Fred Md.

24. FUNERAL DIRECTOR: Fiete Funeral Home — ADDRESS: Brunswick

25a. REC'D BY REGISTRAR DATE: MAR 1 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #9 Film #G385 2/20/67 pc

02022

CERTIFICATE OF DEATH

02017

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside carparate limits, write RURAL and give nearest tawn): Sykesville
c. LENGTH OF STAY IN 1b: 2 years
d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give street address): Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside carparate limits, write RURAL and give nearest tawn): Baltimore
d. STREET ADDRESS: 334 W. 29th Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Frank	Constantino	Arven	Febuary	10	1967

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	WIDOWED ☒	1/1/79	89/88 yrs.				

10a. USUAL OCCUPATION (Give kind of wark dane during mast of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Cook		Turkey	U.S.A. Naturaliz

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Constantine Aventopolis	Olympia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na, or unknawn) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
No	220-54-6317	Springfield State Hospital Records

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter anly one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma of Esophagus — INTERVAL BETWEEN ONSET AND DEATH
150X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic brain syndrome assoc. with senile brain disease with psychotic Read — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 2/20/66, 1966 to 2/10/67, 1967, that (I) (we) last saw the deceased alive on 2/10/67 1967, and that death occurred at 10:30 P.M., from couses and on the date stated above.

22a. SIGNATURE: H E Connorr — M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☑ — 22b. DATE SIGNED: 2/10/67

22c. PHYSICIAN'S NAME (Type): H. E. Connorr M.D.
22d. ADDRESS: Springfield State Hospital Sykesville

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	2/14/67	Mays Chapel	Baltimpre Co. Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Wm. Cook-Brooks Inc. Baltimore, Md. 21202	FEB 16 1967	J Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02023

CERTIFICATE OF DEATH

02018

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Millers
c. LENGTH OF STAY IN 1b: 18 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)
a. STATE: Md. — b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Millers
d. STREET ADDRESS: Ok.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Samuel — Middle: B. — Last: Asper

4. DATE OF DEATH: Month: Feb. — Day: 7, — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: Jan. 27, 1883

9. AGE (In years last birthday): 84 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Carroll Co. Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Samuel J. Asper

14. MOTHER'S MAIDEN NAME: Mary Brown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): NO

16. SOCIAL SECURITY NO.: 220-28-8862

17. INFORMANT — Address: George E. Asper — Parkton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Chronic Myocarditis
DUE TO (b): Arteriosclerotic Cardiovascular disease
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: ?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)**

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. / p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from JAN 12, 1967 to February 7, 1967, that (I) (we) last saw the deceased alive on Feb 3, 1967 and that death occurred at 8A M, from the causes and on the date stated above.

22a. SIGNATURE: Joseph E Bush M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2-7-67

22c. PHYSICIAN'S NAME (Type): Joseph E. Bush MD

22d. ADDRESS: HAMPSTEAD Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2/10/67

23c. NAME OF CEMETERY OR CREMATORY: St. Paul's Cemetery

23d. LOCATION (City, town or county) (State): Upperco, Md.

24 FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Tipton - Eline Funeral Home Hampstead, Md.

25a. REC'D BY REGISTRAR DATE: FEB 9 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is to be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7-62

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02024 02019

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Carroll
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Manchester
c. LENGTH OF STAY IN 1b: 3wks 4days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Longview Nursing Home

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Balt
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Catonsville Maryland
d. STREET ADDRESS: 70 Mellor ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Joseph Middle: X Last: Barker Sr.
4. DATE OF DEATH: Month: Feb Day: 25 Year: 1967
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 2-10-1888
9. AGE (In years last birthday): 78 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): School Custodian
10b. KIND OF BUSINESS OR INDUSTRY: Public School
11. BIRTHPLACE (County & State, or foreign country): Catonsville Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: JEREMIAH BARKER
14. MOTHER'S MAIDEN NAME: Caroline BELL
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 24-38-4054
17. INFORMANT: Joseph N. Barker Sr Address: 113 Bloomsbury ave Catonsville Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Lobar Pneumonia
DUE TO (b): Arteriosclerotic Cardiovascular Disease
DUE TO (c):
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: 2-20-67 / 1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from JAN 31 1967, to Feb 25, 1967, that (I) (we) last saw the deceased alive on Feb 24 1967, and that death occurred at 7 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Joseph E Bush M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Feb 25, 1967
22c. PHYSICIAN'S NAME (Type): Joseph E. Bush MD
22d. ADDRESS: Hampstead Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 2/28/67
23c. NAME OF CEMETERY OR CREMATORY: Meadow Ridge
23d. LOCATION (City, town or county) (State): Md.

24. FUNERAL DIRECTOR: E.B. MacNabb ADDRESS: 301 Frederick Rd Balto 28 Md
25a. REC'D BY REGISTRAR DATE: FEB 28 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02025

CERTIFICATE OF DEATH

02020

1. PLACE OF DEATH
a. COUNTY: CARROLL COUNTY — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): WESTMINSTER
c. LENGTH OF STAY IN 1b: 16 YRS.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): BOX 224 WASHINGTON ROAD

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: CARROLL
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): WESTMINSTER 06-1
d. STREET ADDRESS: WASHINGTON ROAD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOHN Middle WILLIAM Last BARNES

4. DATE OF DEATH: Month FEB. Day 14 Year 1967

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: OCT 9 1871

9. AGE (In years last birthday): 95 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER

10b. KIND OF BUSINESS OR INDUSTRY: FARM.

11. BIRTHPLACE (County & State, or foreign country): GAMBER, MD.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: FRANK BARNES

14. MOTHER'S MAIDEN NAME: MARY LOCKARD

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes give war or dates of service): —

16. SOCIAL SECURITY NO.: 219-20-3099

17. INFORMANT: SON. RAYMOND P. BARNES
Address: 224 WASHINGTON RD WESTMINSTER, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs
4201
DUE TO (b):
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Gastroenteritis, viral

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 2/19, 1953, to 2/14, 1967, that (I) (we) last saw the deceased alive on 2/14 1967, and that death occurred at M, from the causes and on the date stated above.

22a. SIGNATURE: Julius Chepko — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2/15/67

22c. PHYSICIAN'S NAME (Type): JULIUS CHEPKO

22d. ADDRESS: 85½ W. GREEN ST. WESTMINSTER MD

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 2/18/67

23c. NAME OF CEMETERY OR CREMATORY: PROVIDENCE CEM.

23d. LOCATION (City, town or county) (State): GAMBER, MD.

24. FUNERAL DIRECTOR: James G. Saffell Jr. — ADDRESS: WESTMINSTER, MD.

25a. REC'D BY REGISTRAR DATE: FEB 17 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02026 02021

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. **PLACE OF DEATH**
   a. COUNTY: Carroll Co. — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WESTMINSTER MD.
   c. LENGTH OF STAY IN 1b: 25 YRS.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): CARROLL Co. GEN. HOSPITAL

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: MARYLAND
   b. COUNTY: CARROLL
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WESTMINSTER
   d. STREET ADDRESS: 102 PENNA. AVE.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First MONROE Middle W. Last BEAR

4. **DATE OF DEATH**: Month 2 Day 23 Year 1967

5. SEX: MALE

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 9-26-1909

9. AGE (In years last birthday): 57 yrs.

IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SERVICE MAN, OIL BURNERS & AIR CONDITIONERS

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ERNEST P. BEAR

14. MOTHER'S MAIDEN NAME: NINA B. MARTIN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ___ (If yes give war or dates of service) ___

16. SOCIAL SECURITY NO.: 214-01-1739

17. **INFORMANT**: Mrs. Monroe W. Bear Address: Same

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): DEHYDRATION, INANITION
DUE TO (b): METASTATIC CARCINOMA, ABDOMEN
DUE TO (c): CARCINOMA OF COLON
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1538
INTERVAL BETWEEN ONSET AND DEATH: 4 MONTHS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): NONE

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 2-10-, 1966, to 2-22-, 1967, that (I) (~~we~~) last saw the deceased alive on 2-22-1967, and that death occurred at 4:10 AM, from causes and on the date stoted above.

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2-23-1967

22c. PHYSICIAN'S NAME (Type): HANS NIPKOW, MD

22d. ADDRESS: RT 4 BOX 413 WESTMINSTER, MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2/25/67

23c. NAME OF CEMETERY OR CREMATORY: Meadow Branch Cemetery

23d. LOCATION (City or Town) (County) (State): Rural, Westminster, Md.

24. FUNERAL DIRECTOR ADDRESS: J. E. Myers, Jr. Westminster, Md.

25a. REC'D BY REGISTRAR DATE: FEB 28 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02027 02022

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal; and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 2yrs.4mos.26dys.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 601 E. 30th St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First SVEN; Middle SVENSON; Lost BERGLOWE

4. DATE OF DEATH: Month FEBRUARY; Doy 3; Year 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 7-3-1883

9. AGE (In years last birthday): 83 yrs.

IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired carpenter

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & Stote, or foreign country): Sweden, (Stockholm)

12. CITIZEN OF WHAT COUNTRY? U.S.A. (Nat.)

13. FATHER'S NAME: Sven A. Svenson

14. MOTHER'S MAIDEN NAME: ~~Anna Brigata~~ Britte Olivia Larsen

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give wor or dates of service):

16. SOCIAL SECURITY NO.: 212-09-3811

17. INFORMANT: Address: Records, Springfield State Hospital

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): Infected bedsores
DUE TO
(b): Arteriosclerotic cardiovascular disease
DUE TO
(c):
Conditions, if ony, which gove rise to immediote couse (o), stoting the underlying couse lost.
4221
INTERVAL BETWEEN ONSET AND DEATH: Weeks / Years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o): CBS assoc. with senile brain disease, with psychotic reaction

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)

20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19

20d. INJURY OCCURRED While ot work ☐ Not While ot work ☐

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)

20f. (City or town) (County) (Stote)

21. **I certify** that (I) (this haspital) attended the deceased from 9-7-64, 19__ to 2-3-67, 19__, that (I) (we) last saw the deceased alive an 2-3-67 19__, and that death accurred at 10:30 A.M., from causes and an the date stated abave.

22a. SIGNATURE: Dr. Antonius Glahn M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 2/3/67

22c. PHYSICIAN'S NAME (Type): Antonius Glahn, M. D.

22d. ADDRESS: Springfield State Hospital Sykesville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2/6/67

23c. NAME OF CEMETERY OR CREMATORY: Lorraine Park Cemetery

23d. LOCATION (City or Town) (County) (Stote): Baltimore, M.d. 21207

24. FUNERAL DIRECTOR ADDRESS: Loring Byers-8728 Liberty Rd. Randallstown, Md.

25a. REC'D BY REGISTRAR DATE: FEB 7 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02028

CERTIFICATE OF DEATH

02023

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Grandview Convalescent Home

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sparks
d. STREET ADDRESS: Belfast Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Phoebe — Middle: A. — Last: Bissell

4. DATE OF DEATH: Month: Feb. — Day: 11 — Year: 19 67

5. SEX: F

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: 10/5/1881

9. AGE (In years last birthday): 85 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Cottage Mother

10b. KIND OF BUSINESS OR INDUSTRY: Montrose School

11. BIRTHPLACE (County & State, or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Benjamin Bissell

14. MOTHER'S MAIDEN NAME: Eliza Henshaw

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Harry Bissell-3603 Briarstone Rd. Address: Randallstown

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 15 minutes
DUE TO (b): Hypertension - with generalized arteriosclerosis — 4 years
DUE TO (c): Myocarditis - decompensation — years
Diabetes — years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
260X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1-1-45, 19__ to 2-11-67, 19__, that (I) (we) last saw the deceased alive on 2-10-67, and that death occurred at 7:30 P.M., from causes and on the date stated above.

22a. SIGNATURE: James G. Saffell — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2-11-67

22c. PHYSICIAN'S NAME (Type): James G. Saffell

22d. ADDRESS: Reisterstown, Balto Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2/13/67

23c. NAME OF CEMETERY OR CREMATORY: Rock Spring Episcopal Church Forrest Hills, Md. 21050

23d. LOCATION (City or Town) (County) (State)

24. FUNERAL DIRECTOR: Loring Byers — ADDRESS: 8728 Liberty Rd. Randallstown, Md.

25a. REC'D BY REGISTRAR DATE: FEB 14 1967

25b. REGISTRAR'S SIGNATURE: Charles Gray

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02029 02024

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hampstead
c. LENGTH OF STAY IN 1b: 4 hours
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Black & Decker Mfg. Co.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Owings Mills
d. STREET ADDRESS: 21 Ritters Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First THOMAS — Middle ALVEY — Last BLAIR

4. DATE OF DEATH: Month February — Day 1, — Year 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: May 5, 1915

9. AGE (In years last birthday): 51 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Draftsman & Tool Designer

10b. KIND OF BUSINESS OR INDUSTRY: Black & Decker Mfg.

11. BIRTHPLACE (County & State, or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: James Blair

14. MOTHER'S MAIDEN NAME: Aurelia M. Dickernhoff

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service): -

16. SOCIAL SECURITY NO.: 212-03-0516

17. INFORMANT: Mrs. Louise B. Blair — Address: 21 Ritters Lane, Owings Mills, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Minutes
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour e.m. / p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from From May 19 67 to Feb 1, 19 67, that (I) (we) last saw the deceased alive on January 20 1967, and that death occurred at 11:15 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Clarence E. McWilliams M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: Feb 2, 1967

22c. PHYSICIAN'S NAME (Type): Clarence E. McWilliams

22d. ADDRESS: Westminster Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2/4/67

23c. NAME OF CEMETERY OR CREMATORY: Blue Ridge Cemetery

23d. LOCATION (City, town or county) (State): Thurmont, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: H. J. Eckhardt

ADDRESS: Owings Mills, Md.

25a. REC'D BY REGISTRAR DATE: FEB 6 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is to be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A15 (4)
15M 7-62

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02030

CERTIFICATE OF DEATH

02025

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): (Rural) Sykesville
c. LENGTH OF STAY IN 1b: 0y. 3m. 25d
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kensington 20795
d. STREET ADDRESS: 5213 White Flint Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
	William	Joseph	Brosnan		2	23	19 67

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
male	White		6-18-86	80 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	---	Pennsylvania	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Timothy Brosnan	Mary E. Fallon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
none	163-14-2489	Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: days
DUE TO (b): Heart Failure — weeks
DUE TO (c): Arteriosclerotic heart disease — years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic brain syndrome, associated with senile brain disease with psychotic reaction.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
	--

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
-- 19	--		--

21. **I certify** that (I) (this hospital) attended the deceased from 10-28, 1966, to 2-23, 19 67 that (I) (we) last saw the deceased alive on 2-23, 19 67, and that death occurred at 4:40 AM, from causes and on the date stated above.

22a. SIGNATURE	M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒	22b. DATE SIGNED
Arsenio Sariano M.D.		2-23-67

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
Sariano, M.D.	Springfield State Hospital

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	2/25/67	Parklawn	Rockville, Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Tyson Wheeler Funeral Home-1331 Rockville Pike Rockville, Md.	FEB 27 1967	J. Charles Jones

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02031

CERTIFICATE OF DEATH

02026

1. PLACE OF DEATH
a. COUNTY: Carroll
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 2 mo, 8 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: —
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 4663 Park Heights Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WILLIAM Middle THOMAS Last CARTER

4. DATE OF DEATH: Month February Doy 13 Year 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: 7-18-86

9. AGE (In years lost birthday) 80 yrs.

IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Chauffeur

10b. KIND OF BUSINESS OR INDUSTRY: ____

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John Wesley Carter

14. MOTHER'S MAIDEN NAME: Mary Allen

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes give wor or dotes of service)

16. SOCIAL SECURITY NO.: 214-41-7833

17. INFORMANT Address: Records, Springfield State Hospital

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Heart failure — INTERVAL BETWEEN ONSET AND DEATH: Weeks
DUE TO
(b): Arteriosclerotic heart disease — years
DUE TO
(c): ____

4200
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Chronic brain syndrome assoc., with senile brain disease without qualifying phrase.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 12-5-66, 19__, to 2-13, 1967, that (I) (we) last saw the deceased alive on 2-13-67, 19__, and that death occurred at 2:35 P.M. from causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 2-13-67

22c. PHYSICIAN'S NAME (Type): Jorge Gonzales, M.D.

22d. ADDRESS: Springfield State Hospital, Sykesville

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2/17/67

23c. NAME OF CEMETERY OR CREMATORY: New Cathedral

23d. LOCATION (City or Town) (County) (State): Baltimore, Md.

24. FUNERAL DIRECTOR ADDRESS: Wm. Cook-Brooks Inc Baltimore, Md. 21202

25a. REC'D BY REGISTRAR DATE: FEB 23 1967

25b. REGISTRAR'S SIGNATURE: [signature]

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 8 Film G586 2/27/67 mh

CERTIFICATE OF DEATH

02032 02027

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural--Sykesville
c. LENGTH OF STAY IN 1b: lyr. 10days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville 06-1
d. STREET ADDRESS: --
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Amanda; Middle: Elizabeth; Last: Clark
4. DATE OF DEATH: Month: 2; Day: 21; Year: 1967

5. SEX: female
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 12/21/91 1890
9. AGE (In years last birthday): 76 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): domestic
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: unknown
14. MOTHER'S MAIDEN NAME: Neugent

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 220-54-6667
17. INFORMANT Address: Springfield Hospital records, Sykesville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac failure — INTERVAL BETWEEN ONSET AND DEATH: days
DUE TO (b): Nephrosclerosis — days
DUE TO (c): Diabetes Mellitus — years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 260 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic brain syndrome associated with cerebral arteriosclerosis with psychotic reaction.
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 2/11/ , 1966 to 2/21/ , 1967, that (we) last saw the deceased alive on 2/21/ 1967, and that death occurred at 9:15 A.M., from causes and on the date stated above.

22a. SIGNATURE: Naci N. Buyukunsal M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 2/21/67
22c. PHYSICIAN'S NAME (Type): Naci N. Buyukunsal, M. D.
22d. ADDRESS: Springfield State Hospital Sykesville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 2-23-67
23c. NAME OF CEMETERY OR CREMATORY: White Rock Cemetery
23d. LOCATION (City or Town) (County) (State): Sykesville Md.

24. FUNERAL DIRECTOR: Harry W. Wright ADDRESS: Sykesville, Md.
25a. REC'D BY REGISTRAR DATE: FEB 24 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02033

CERTIFICATE OF DEATH

02028

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: Carroll — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Rural - Sykesville
   c. LENGTH OF STAY IN 1b: Life
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): old Liberty Road

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Md. — b. COUNTY: Carroll
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Sykesville 067
   d. STREET ADDRESS: old Liberty Road
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William — Middle: G. — Last: Cockey

4. DATE OF DEATH: Month: Feb. — Day: 17 — Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Nov. 7 1878

9. AGE (In years last birthday): 88 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (County & State, or foreign country): ~~Mrs. Allan Reynolds~~ Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Wm H. Cockey

14. MOTHER'S MAIDEN NAME: Gertrude Knode

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes — (If yes give war or dates of service): Spanish-American

16. SOCIAL SECURITY NO.: 215-54-3056

17. INFORMANT — Address: Mrs Allan Reynolds - Sykesville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): LEFT VENTRICULAR FAILURE — INTERVAL BETWEEN ONSET AND DEATH: 2 days

Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. 4221

DUE TO (b): CONGESTIVE HEART FAILURE — 5 yrs.

DUE TO (c): A, S, C, V. D. — 30 yrs?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Senile arteriosclerosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from FEB, 1967, to FEB 17, 1967, that (I) (we) last saw the deceased alive on 2-17-1967, and that death occurred at 7:00 AM, from the causes and on the date stated above.

22a. SIGNATURE: R. V. Houck Jr. — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 2-17-67

22c. PHYSICIAN'S NAME (Type): R. V. HOUCK JR — 22d. ADDRESS: SYKESVILLE MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 2-20-67 — 23c. NAME OF CEMETERY OR CREMATORY: Lake View Cemetery — 23d. LOCATION (City, town or county) (State): Sykesville Md.

24. FUNERAL DIRECTOR — ADDRESS: Harry W. Haight Sykesville, Md. — 25a. REC'D BY REGISTRAR DATE: FEB 21 1967 — 25b. REGISTRAR'S SIGNATURE: J. Charles Jones

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02034 — 02029

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely executed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 15M 7-62

1. PLACE OF DEATH — a. COUNTY: Carroll — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westminster
   c. LENGTH OF STAY IN 1b: 1 MONTH
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Longview Nursing Home

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) — a. STATE: Maryland — b. COUNTY: Carroll
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westminster, Maryland 21-1
   d. STREET ADDRESS: 60 Pennsylvania Ave
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Chauncey — Middle: C — Last: Day

4. DATE OF DEATH: Month: Feb — Day: 12 — Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: May 19, 1886

9. AGE (In years last birthday): 80 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Minister

10b. KIND OF BUSINESS OR INDUSTRY: Gospel

11. BIRTHPLACE (County & State, or foreign country): Stewartstown Pa York County

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Emory M. Day

14. MOTHER'S MAIDEN NAME: Sarah Duff

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 220-34-8108

17. INFORMANT: Chauncey Day — Address: Westminster Md

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
- IMMEDIATE CAUSE (a): Cerebral Hemorrhage — 1143X — INTERVAL BETWEEN ONSET AND DEATH: ?
- DUE TO (b): Arteriosclerotic Cardiovascular Disease — ?
- DUE TO (c): Hypertension

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED — While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1-10, 1967, to 2-12, 1967, that (I) (we) last saw the deceased alive on 2-11 1967, and that death occurred at 4:30 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Joseph E. Bush M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 2-12-67

22c. PHYSICIAN'S NAME (Type): Joseph E. Bush MD — 22d. ADDRESS: Hampstead Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 2/14/67 — 23c. NAME OF CEMETERY OR CREMATORY: Evergreen Memorial Gardens — 23d. LOCATION (City, town or county) (State): Finksburg, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: J. E. Myers Jr. — ADDRESS: Westminster, Md.

25a. REC'D BY REGISTRAR DATE: FEB 14 1967 — 25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02035

CERTIFICATE OF DEATH

02030

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN Ib: 36 yrs./17 das.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived, if institutian: Residence before admission)
a. STATE: Maryland
b. COUNTY: Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give neorest town): Cumberland
d. STREET ADDRESS: 33 Weber Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Playford — Middle: NMN — Last: DEAHL

4. DATE OF DEATH: Month: February — Day: 17, — Year: 1967

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3-24-1914

9. AGE (In years last birthday): 52 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most af working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & Stote, or foreign country): West Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John M. Deahl

14. MOTHER'S MAIDEN NAME: Bertha V. Lininger

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates af service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Springfield State Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bilateral Lobar Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: Days
490X
DUE TO (b):
Conditians, if any, which gave rise ta immediate couse (a), stating the underlying couse last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic Schizophrenia

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture af injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Nat While at work ☐

20e. PLACE OF INJURY (Home, farm, factary, street, office bldg., etc.)

20f. (City ar town) (County) (State)

21. I certify that (I) (this haspital) attended the deceased from 2-1-31, 19__ ta 2-17-67, 19__, that (I) (we) last saw the deceased alive an 2-17-67 19__, and that death accurred at 10:30 P.m. from causes and an the date stated above.

22a. SIGNATURE: Glouifo G. Sagisi — M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 2-17-67

22c. PHYSICIAN'S NAME (Type): Glouifo G. Sagisi, M.D.

22d. ADDRESS: Springfield State Hospital Sykesville, Maryland 21784

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2/23/67

23c. NAME OF CEMETERY OR CREMATORY: Shady Grove Cemetery

23d. LOCATION (City or Town) (County) (State): Brandonville W. Va

24. FUNERAL DIRECTOR: H. Lee Silcox — ADDRESS: Cumberland, Maryland

25a. REC'D BY REGISTRAR DATE: FEB 23 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02036

CERTIFICATE OF DEATH

02031

1. PLACE OF DEATH
a. COUNTY: Carroll
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural--Sykesville
c. LENGTH OF STAY IN 1b: 3m. 24days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived, if institutian: Residence before admission)
a. STATE: Maryland
b. COUNTY: —
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 6205 Eunice Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mildred; Middle: Eliza; Last: Debelius

4. DATE OF DEATH: Month: 2; Day: 21; Year: 1967

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3/23/82

9. AGE (In yeors last birthday) 84 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles Hall

14. MOTHER'S MAIDEN NAME: Henrietta Mullin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes give wor or dotes of service)

16. SOCIAL SECURITY NO.: unk.

17. INFORMANT Address: Springfield Hospital records, Sykesville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Septicemia and acute meningitis(organism unkn.) — INTERVAL BETWEEN ONSET AND DEATH: days
491X
Conditians, if any, which gove rise to immediate cause (a), stoting the underlying couse lost.
DUE TO (b): Infected decubitus ulcers. — weeks
DUE TO (c): Bronchopneumonia. — days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic brain syndrome associated with senile brain disease with psychotic reaction.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 10/27/, 1966, to 2/21/, 1967, that (I) (we) last saw the deceased alive an 2/21/ 1967, and that death occurred at 2:00 aM, from causes and on the date stated above.

22a. SIGNATURE: Edmee J. Reeves
M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 2/21/67

22c. PHYSICIAN'S NAME (Type): Edmee J. Reeves, M. D.

22d. ADDRESS: Springfield State Hospital Sykesville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Feb 24, 67

23c. NAME OF CEMETERY OR CREMATORY: Oak Lawn

23d. LOCATION (City or Town) (County) (State): Baltimore Md

24. FUNERAL DIRECTOR: T A Heemann

ADDRESS: 1067 Hart Rd

25a. REC'D BY REGISTRAR DATE: FEB 27 1967

25b. REGISTRAR'S SIGNATURE: [illegible] Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02037 — **CERTIFICATE OF DEATH** — 02032

Item 2 filled 2/24/67 mh

1. PLACE OF DEATH
a. COUNTY: CARROLL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville, Md.
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Pollen Nursing Home First Ave

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Carroll ~~Montgomery~~
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Springfield State Hospital Takoma Park 15
d. STREET ADDRESS: Sykesville, Md.
6. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Elizabeth — Middle — Last Deller
4. DATE OF DEATH: Month Feb. — Day 15, — Year 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Nov. 10, 1883
9. AGE (In years last birthday): 83 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service): —
16. SOCIAL SECURITY NO.: ?
17. INFORMANT: Mae Pollen — Address: Sykesville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic heart disease, Cardiac failure,
DUE TO (b): Carcinoma of the bowel, arteriosclerosis, gen-
DUE TO (c): erlized; Chronic Brain Syndrome.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 1960 through 1967

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1960, 19__, to Feb. 15, 19 67, that (I) (we) last saw the deceased alive on Feb. 15, 19 67, and that death occurred at 11 A.M, from the causes and on the date stated above.

22a. SIGNATURE: Howard E Hall M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Feb. 15, 1967
22c. PHYSICIAN'S NAME (Type): Howard E. Hall, M.D.
22d. ADDRESS: Sykesville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 2-18-67
23c. NAME OF CEMETERY OR CREMATORY: Freedom Cemetery
23d. LOCATION (City, town or county) (State): Sykesville, Md.

24. FUNERAL DIRECTOR: Harry W. Haight — ADDRESS: Sykesville, Md.
25a. REC'D BY REGISTRAR DATE: FEB 20 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02038 02033

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH a. COUNTY: Carroll MARYLAND	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: Maryland b. COUNTY: Allegany
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural--Sykesville c. LENGTH OF STAY IN 1b: 5y. 3m. 26d.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lonaconing
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): Springfield State Hospital	d. STREET ADDRESS: 36 E. Main Street e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)	First	Middle	Lost	4. DATE OF DEATH	Month	Doy	Year
	Ruth	Evelyn	Dick		2	16	19 67

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In yeors last birthday)	IF UNDER 1 YEAR Months / Doys	IF UNDER 24 HRS. Hours / Min.
female	white		4/8/19	47 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & Stote, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
factory worker		Maryland	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
James Russell Dick	Bertha Bishop

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
no	212-12-8299	Springfield Hospital records, Sykesville, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (o), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): Heart failure — INTERVAL BETWEEN ONSET AND DEATH: weeks
DUE TO (b): Coronary artery arteriosclerosis and insufficiency — years
DUE TO (c):

4201
Conditions, if ony, which gave rise to immediote cause (o), stoting the underlying couse lost.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o): Chronic brain syndrome associated with Huntington's Chorea without qualifying phrase.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20o. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Doy, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While ot work ☐ Not While ot work ☐	20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. **I certify** thot ~~I~~ (this hospitol) ottended the deceased from 10/20/, 1961, to 2/16/, 1967, thot ~~I~~ (we) lost sow the deceased olive on 2/16/ 1967, ond thot deoth occurred ot 9:15a M, from couses ond on the dote stoted above.

22o. SIGNATURE	M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒	22b. DATE SIGNED
Naci Buyukunsal		2/16/67

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
Naci N. Buyukunsal, M.D.	Springfield State Hospital Sykesville, Maryland

23o. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	2/19/1967	Oak Hill Cemetery	Lonaconing, MD.

24. FUNERAL DIRECTOR	ADDRESS	25o. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
GEORGE EICHHORN	Lonaconing, MD.	FEB 20 1967	Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02039

CERTIFICATE OF DEATH

02034

1. PLACE OF DEATH
a. COUNTY: CARROLL — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): WESTMINSTER
c. LENGTH OF STAY IN 1b: 41 YRS.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 28 WEBSTER ST.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WESTMINSTER
d. STREET ADDRESS: 28 WEBSTER ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WILLIAM — Middle FRANCIS — Last DOYLE

4. DATE OF DEATH: Month FEB. — Day 23 — Year 1967

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ — NEVER MARRIED ☐ — WIDOWED ☐ — DIVORCED ☐

8. DATE OF BIRTH: MAY 5 1874

9. AGE (In years last birthday): 92 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED FARMER

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): CARROLL CO MD.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: MATTHEW DOYLE

14. MOTHER'S MAIDEN NAME: ELIZABETH DONNELLY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): —
(If yes give war or dates of service): —

16. SOCIAL SECURITY NO.: —

17. INFORMANT: MRS. WILLIAM F. DOYLE, Address SAME ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardio Vascular Renal Disease — INTERVAL BETWEEN ONSET AND DEATH: Several yrs
442X
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerosis (Gen'l) — yrs
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan 15' 1964 to Feb 23 1967, that (I) (we) last saw the deceased alive on Feb 22 1967, and that death occurred at 11:50 A.M., from the causes and on the date stated above.

22a. SIGNATURE: William Speicher — M.O. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 2-24-67

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 2/27/67 — 23c. NAME OF CEMETERY OR CREMATORY: WESTMINSTER CEMETERY — 23d. LOCATION (City, town or county) (State): WESTMINSTER MD.

24. FUNERAL DIRECTOR — ADDRESS: J. E. Myers Jr., Westminster, Md.

25a. REC'D BY REGISTRAR DATE FEB 28 1967 — 25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02040

CERTIFICATE OF DEATH

02035

1. PLACE OF DEATH
   a. COUNTY: Carroll — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hampstead
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 334 Main Street

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Md. b. COUNTY: Carroll
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hampstead
   d. STREET ADDRESS: 334 Main Street
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Blanche — Middle: J. — Last: Eburg

4. DATE OF DEATH: Month: February — Day: 4, — Year: 19 67

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Jan. 31, 1902

9. AGE (In years last birthday): 65 yrs.
   IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): West Virginia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John W. Frush

14. MOTHER'S MAIDEN NAME: Lula Belle Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
   (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mr. Charles E. Eburg — Address: Hampstead, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 5 min

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) Arteriosclerotic C.V. Disease — 5 or 6 yrs
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 5-25, 1960, to 2-4, 1967, that (I) (we) last saw the deceased alive on 2-4 1967, and that death occurred at 2:45 M, from the causes and on the date stated above.

22a. SIGNATURE: M.C. Porterfield — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2-6-67

22c. PHYSICIAN'S NAME (Type): M.C.Porterfield

22d. ADDRESS: Hampstead,Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2/7/67

23c. NAME OF CEMETERY OR CREMATORY: Hampstead Cemetery

23d. LOCATION (City, town or county) (State): Hampstead, Md.

24. FUNERAL DIRECTOR: Tipton-Eline Funeral Home — ADDRESS: Hampstead, Md.

25a. REC'D BY REGISTRAR DATE: FEB 8 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02041

CERTIFICATE OF DEATH

02036

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. **PLACE OF DEATH**
   a. COUNTY: Carroll — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SYKESVILLE
   c. LENGTH OF STAY IN 1b: 5 MO
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): Springfield State Hosp

2. **USUAL RESIDENCE** (Where deceosed lived, if institution: Residence before odmission)
   a. STATE: Maryland — b. COUNTY: Carroll
   c. CITY OR TOWN (If outside corporate limits, write RURAL ond give neorest town): Westminster
   d. STREET ADDRESS: 66 W. Green Street
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Norman — Middle: Claude — Lost: Erb

4. **DATE OF DEATH**: Month: FEB. — Doy: 11 — Year: 1967

5. SEX: Male

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 6-3-83

9. AGE (In years lost birthday): 83 yrs.

IF UNDER 1 YEAR: Months / Doys — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Contractor

10b. KIND OF BUSINESS OR INDUSTRY: (Building)

11. BIRTHPLACE (County & Stote, or foreign country): Taneytown, Rd. Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Henry Erb

14. MOTHER'S MAIDEN NAME: Sarah Ellen Keefer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 216-20-9951

17. INFORMANT — Address: Mrs N. Claude Erb 66 W. Green St. Westminster

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), ond (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): Acute heart Failure
   DUE TO (b):
   Conditions, if ony, which gove rise to immediote couse (a), stoting the underlying couse lost. DUE TO (c): CBS assisted accute brain disease psychotic Reaction
   304X
   INTERVAL BETWEEN ONSET AND DEATH

   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19

20d. INJURY OCCURRED While ot work ☐ Not While ot work ☐

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this haspital) attended the deceased from 9-12, 1966, to 2-11, 1967, that (I) (we) last saw the deceased alive an 2-11 1967, and that death accurred at 2:30P M, fram causes and an the date stated abave.

22a. SIGNATURE: R. C. Lajonchere MD — M.D. ☐ ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2-14-67

22c. PHYSICIAN'S NAME (Type): R. C. LAJONCHERE MD

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2/15/67

23c. NAME OF CEMETERY OR CREMATORY: St Mary's Cemetery

23d. LOCATION (City or Town) (County) (State): Silver Run Carroll Co Md.

24. FUNERAL DIRECTOR — ADDRESS: J. E. Myers Jr. Westminster, Md.

25a. REC'D BY REGISTRAR — DATE: FEB 14 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Jones

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
3500 4-64

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02042

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02037

Item 8 Film G386 3/27/67 mh

1. PLACE OF DEATH
a. COUNTY: Carroll
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): (Rural) Sykesville
c. LENGTH OF STAY IN 1b: 30yr. 4mo. 21d
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville, Maryland
d. STREET ADDRESS: --
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First John Middle Harrison Last Eldridge

4. DATE OF DEATH: Month 2 Day 21 Year 1967

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 2-27-11 1910

9. AGE (In years last birthday): 56 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: --

11. BIRTHPLACE (State or foreign country): Tennessee

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John H. Eldridge

14. MOTHER'S MAIDEN NAME: Gladys Wilson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no
(If yes give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT Address: Hospital Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bi-lateral Lobar Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: days
490X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Schizophrenic reaction, paranoid type

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: W. Glenn Speicher M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): W. Glenn Speicher
Address (Street, city, town, or county): 135 E. Main, Westminster, Carroll (County)

22. DATE SIGNED: 2-21-67

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
23b. DATE THEREOF: 2-22-67
23c. NAME OF CEMETERY OR CREMATORY: Lee's Crematory
23d. LOCATION (City, town or county): Washington, (State) D.C.

24. FUNERAL DIRECTOR: Harry W. Haight ADDRESS: Sykesville, Md.

25a. REC'D BY REGISTRAR DATE: FEB 24 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02043

CERTIFICATE OF DEATH

02038

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corparate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 1yr.8mos.22dys.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived, if institutian: Residence before admission)
a. STATE: Maryland
b. COUNTY: Washington
c. CITY OR TOWN (If outside corparate limits, write RURAL and give nearest town): Hagerstown
d. STREET ADDRESS: 1059 Florida Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WALTER — Middle FRANKLIN — Last ENSOR

4. DATE OF DEATH: Month FEBRUARY — Day 20 — Year 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 9-2-07

9. AGE (In years last birthday): 59 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of wark dane during mast af working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, ar fareign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Howard Ensor

14. MOTHER'S MAIDEN NAME: Alva B. Fogle

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, ar unknawn) (If yes give war ar dates af service): No

16. SOCIAL SECURITY NO.: None 218-24-1354

17. INFORMANT — Address: Records, Springfield State Hospital

MEDICAL CERTIFICATION

1B. CAUSE OF DEATH (Enter anly ane cause per line far (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac arrest — INTERVAL BETWEEN ONSET AND DEATH: Minutes
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Acute myocardial infarction — Hours
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Schizophrenic reaction, chronic undifferentiated type

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature af injury in Part I ar Part II af item 1B.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Nat While at work ☐

20e. PLACE OF INJURY (Home, farm, factary, street, affice bldg., etc.)

20f. (City ar tawn) (County) (State)

21. **I certify** that (I) (this haspital) attended the deceased from 5-28-65, 19__, to 2-20-67, 19__, that (I) (we) last saw the deceased alive an 2-20-67, 19__, and that death accurred at 3:15 P.M., from causes and an the date stated above.

22a. SIGNATURE: Octavio A Ruiz M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 2-21-67

22c. PHYSICIAN'S NAME (Type): Octavio A. Ruiz, M. D.

22d. ADDRESS: Springfield State Hospital Sykesville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2/23/67

23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

23d. LOCATION (City or Tawn) (County) (State): Hagerstown Wash Md.

24. FUNERAL DIRECTOR: Raber & Lanser

ADDRESS: Hagerstown Md

25a. RECD BY REGISTRAR DATE: FEB 24 1967

25b. REGISTRAR'S SIGNATURE: James Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02044

CERTIFICATE OF DEATH

02039

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 7/61

1. **PLACE OF DEATH**
   a. COUNTY: Carroll Co — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westminster
   c. LENGTH OF STAY IN 1b: 6
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 115 Bond St.

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Carroll
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westminster
   d. STREET ADDRESS: 115 Bond St. — 06-1
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: LE ROY — Middle: OLIVER — Last: FARVER

4. **DATE OF DEATH**: Month: FEB. — Day: 14 — Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 30 1898

9. AGE (In years last birthday): 68 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired farmer & watchman at Shoe factory

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Carroll Co. Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Rezin Farver

14. MOTHER'S MAIDEN NAME: Katie Hanes

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): —
(If yes give war or dates of service): —

16. SOCIAL SECURITY NO.: 220-26-7436

17. INFORMANT: Mrs. LeRoy O. Farver — Address: Same address

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion
4201
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: 24 hrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Carcinoma left lung; Congestive Heart failure

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 2/4, 1963, to 2/14, 1967, that (I) (we) last saw the deceased alive on 2/13 1967, and that death occured at 1:50 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Julius Chepko M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2/14/67

22c. PHYSICIAN'S NAME (Type): Julius Chepko

22d. ADDRESS: 85 W Green St. Westminster, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2/16/67

23c. NAME OF CEMETERY OR CREMATORY: Taylorsville Meth. Cem.

23d. LOCATION (City, town or county) (State): Taylorsville, Carroll Co. Md.

24 FUNERAL DIRECTOR'S SIGNATURE: J. E. Myers Jr.

ADDRESS: Westminster, Md.

25a. REC'D BY REGISTRAR: DATE FEB 16 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02045

CERTIFICATE OF DEATH

02040

1. PLACE OF DEATH
a. COUNTY: CARROLL COUNTY — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): GAMBER
c. LENGTH OF STAY IN 1b: 62 YRS
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): RT 91

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): GAMBER
d. STREET ADDRESS: RT # 91
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: AIRY — Middle: GOLDIE — Last: FLATER

4. DATE OF DEATH: Month: FEB — Day: 1 — Year: 1967

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]

8. DATE OF BIRTH: NOV 1, 1884

9. AGE (In years last birthday): 82 yrs.

IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE

10b. KIND OF BUSINESS OR INDUSTRY: HOME

11. BIRTHPLACE (County & State, or foreign country): CARROLL COUNTY

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JABEZ N. BARNES

14. MOTHER'S MAIDEN NAME: KITTIE ELLEN HAINES

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): —

16. SOCIAL SECURITY NO. (If yes give war or dates of service): —
215-50-6918

17. INFORMANT: DAUGHTER — Address: MRS. AIRY G. STANSFIELD GAMBER, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Carcinoma of appendix — INTERVAL BETWEEN ONSET AND DEATH: 5 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Metastasis to entire abdomen & liver — Early — 6 yrs

DUE TO (c): Cachexia

1530

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1-1-, 1930 to 2-1-, 1967, that (I) (we) last saw the deceased alive on 1-31-67, and that death occurred at 11:05 A.M., from the causes and on the date stated above.

22a. SIGNATURE: James G. Saffell M.D. — ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22b. DATE SIGNED: 2-3-67

22c. PHYSICIAN'S NAME (Type): JAMES G. SAFFELL, M.D.

22d. ADDRESS: 64 MAIN ST. REISTERSTOWN, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: FEB. 5, 1967

23c. NAME OF CEMETERY OR CREMATORY: PROVIDENCE CEM.

23d. LOCATION (City, town or county) (State): GAMBER, CARROLL, MD.

24. FUNERAL DIRECTOR: James G. Saffell Jr. — ADDRESS: 254 E. MAIN WESTMINSTER MD.

25a. REC'D BY REGISTRAR DATE: FEB 6 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02046 — 02041

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westminster
c. LENGTH OF STAY IN 1b: 2 Months
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Carroll Co. Gen. Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Sykesville
d. STREET ADDRESS: Rt. 32
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Horatio — Middle: Stanley — Last: Fox Sr.
4. DATE OF DEATH: Month: Feb. — Day: 27. — Year: 1967
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: 12-15-1899
9. AGE (In years last birthday): 67 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Building Mgr.
10b. KIND OF BUSINESS OR INDUSTRY: Building
11. BIRTHPLACE (County & State, or foreign country): Ohio
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Harry Fox
14. MOTHER'S MAIDEN NAME: Sarah Bangs

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service): -----
16. SOCIAL SECURITY NO.: 293 05 5448
17. INFORMANT: Mrs. Carli Fox — Address: Sykesville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Generalized arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Dec 26, 1966 to Feb 27, 1967, that (I) (we) last saw the deceased alive on Feb 27, 1967, and that death occurred at 9:36 A M, from causes and on the date stated above.

22a. SIGNATURE: John S. Harshey — M.D. ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22b. DATE SIGNED: 2/27/67
22c. PHYSICIAN'S NAME (Type): JOHN S. HARSHEY, M.D.
22d. ADDRESS: 8 Anchor St. Westminster, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 3-2-67
23c. NAME OF CEMETERY OR CREMATORY: Mt. Pleasant Cemetery
23d. LOCATION (City or Town) (County) (State): Sykesville Md.

24. FUNERAL DIRECTOR: Harry W. Haight — ADDRESS: Sykesville, Md.
25a. REC'D BY REGISTRAR DATE: MAR 3 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02047 02042

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: CARROLL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WESTMINSTER
c. LENGTH OF STAY IN 1b: 78 HRS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): CARROLL CO. GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WESTMINSTER
d. STREET ADDRESS: 245 W. MAIN ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: ROSA — Middle: ALBERTA — Last: GEIMAN

4. DATE OF DEATH: Month: FEB. — Day: 26 — Year: 1967

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: JAN. 17, 1889

9. AGE (In years last birthday): 78 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (County & State, or foreign country): WESTMINSTER CARROLL Co. Md. U.S.A.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: WILLIAM H. GEIMAN

14. MOTHER'S MAIDEN NAME: ELIZABETH R. WILLIAR

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): —

16. SOCIAL SECURITY NO.: —

17. INFORMANT: MR. CHAS. P. GEIMAN, Address: SAME ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 hours
332X
DUE TO (b): Cerebral arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Feb 25, 1967, to Feb 26, 1967 that (I) (we) last saw the deceased alive on Feb 26, 1967, and that death occurred at 2:30 P.M. from causes and on the date stated above.

22a. SIGNATURE: John S. Harshey M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2/26/67

22c. PHYSICIAN'S NAME (Type): JOHN S. HARSHEY M.D.

22d. ADDRESS: 8 Anchor St Westminster Md

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 2/28/67

23c. NAME OF CEMETERY OR CREMATORY: MEADOW BRANCH CEMETERY

23d. LOCATION (City or Town) (County) (State): WESTMINSTER, MD.

24. FUNERAL DIRECTOR: J. S. Myers Jr. — **ADDRESS**: Westminster, Md

25a. REC'D BY REGISTRAR DATE: FEB 28 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and if any event within 72 hours after death.

VR A1SME (5)
5M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02048

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02043

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 4yrs.8mos.4dys.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 603 Wyeth St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
DOROTHY	DALTON	GORTH	FEBRUARY	23	1967

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	White		5-3-24	42 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None		Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Frederick Gorth	Edith Marney

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
No	None	Records, Springfield State Hospital

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Asphyxia due to occlusion of the entire bronchus — INTERVAL BETWEEN ONSET AND DEATH: Minutes to an hour

DUE TO (b) with recently ingested food

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): CBS assoc. with convulsive disorder, with psychotic reaction

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.): Became cyanosed & suddenly stopped breathing. The doctor was called, who gave emergency care, but to no avail.

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED While at work ☐ Not While at work ☒	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
2-23-1967		Clark Circle	Springfield State Hospital Sykesville Carroll Maryland

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE W. Glenn Speicher M.D. — CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type) W. Glenn Speicher, M. D. — Address (Street, city, town or county) 135 E. King St. Lancaster Pa.

22. DATE SIGNED 2-28-67

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
Burial	2/27/67	London Park Cem.	Balto. Md.

24. FUNERAL DIRECTOR — ADDRESS: John L. Cowan & Sons Inc. 901 Hollins St. Balto. 23 Md.

25a. REC'D BY REGISTRAR DATE: FEB 27 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02043 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 02044

1. PLACE OF DEATH
a. COUNTY CARROLL MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) UNION BRIDGE
c. LENGTH OF STAY IN 1b HOURS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 12 N MAIN STREET

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE
d. STREET ADDRESS 4430 CLAREWAY
a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First ELMER Middle LAWRENCE Last GRAY Sr.
4. DATE OF DEATH Month FEB. Day 19 Year 1967
5. SEX M
6. COLOR OR RACE W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH MAY 23 - 1903
9. AGE (In years last birthday) 63 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) EMPLOYEE
10b. KIND OF BUSINESS OR INDUSTRY HOTEL
11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME GEORGE GRAY
14. MOTHER'S MAIDEN NAME LENORA FICK
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) NO (If yes give war or dates of service)
16. SOCIAL SECURITY NO. 212-12-7017
17. INFORMANT FLORENCE GRAY Address 4430 CLAREWAY BALTIMORE MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis (Acute) — INTERVAL BETWEEN ONSET AND DEATH Sudden
4201
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) Coronary Sclerosis + Obesity — Several yrs
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE W Glenn Speicher M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
22. DATE SIGNED 2-15-67
EXAMINER'S NAME (Type) W GLENN SPEICHER
Address (Street, City or Town, or County) 135 E main Ewo Emmitsburg Md (State)

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
23b. DATE THEREOF 2/23/67
23c. NAME OF CEMETERY OR CREMATORY BEAVER DAM
23d. LOCATION (City, town or county) UNION BRIDGE RURAL MD

24. FUNERAL DIRECTOR ADDRESS DD Hartzler & Sons Union Bridge, Md
25a. REC'D BY REGISTRAR DATE FEB 23 1967
25b. REGISTRAR'S SIGNATURE J Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
350D 4-64

Item 18 Film 387 4-18-67 ams

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
3500 4-64

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02050 02045

1. PLACE OF DEATH
a. COUNTY: Carroll
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 2 yrs. 11 mos.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
e. STATE: Maryland
b. COUNTY: Montg.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silver Spring
d. STREET ADDRESS: 10409 Rodney Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Margaret; Middle: Howe; Last: Greene

4. DATE OF DEATH: Month, Day, Year: 2/10/67 19 67

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 1/11/23
9. AGE (In years last birthday): 44 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10b. KIND OF BUSINESS OR INDUSTRY: Own home
11. BIRTHPLACE (State or foreign country): Oregon
12. CITIZEN OF WHAT COUNTRY? U.S. A.

13. FATHER'S NAME: Robert Gordon Hunt
14. MOTHER'S MAIDEN NAME: Madge Howe

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service): None
16. SOCIAL SECURITY NO.: 534-16-1760
17. INFORMANT: Ernest Greene
Address: 9611 New Hampshire Ave.
Springfield State Hospital Records S.S., Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Asphyxia — INTERVAL BETWEEN ONSET AND DEATH: minutes
355 X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Occlusion of Nose and mouth by pillow — min.
DUE TO (c): Pre-senile degeneration of the brain

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(c): Schizophrenic reaction, Chronic undifferentiated type

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter neture of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☒

ACTUAL SIGNATURE: W. Glenn Speicher M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐
EXAMINER'S NAME (Type): Glenn Speicher M.D.
Address (Street, City, town, or county): 6355 Walker Lane Alexandria Fairfax Va.

22. DATE SIGNED: 2-10-67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Feb 15, 1967
23c. NAME OF CEMETERY OR CREMATORY: Arlington National Cemetery
23d. LOCATION (City, town or county): Arlington, Virginia (State): Va.

24. FUNERAL DIRECTOR: John B. Thomas
ADDRESS: 8434 Georgia Ave.
Warner E. Pumphrey, Inc. Silver Spring, Md.

25a. REC'D BY REGISTRAR
DATE: FEB 16 1967
25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02051 **CERTIFICATE OF DEATH** 02046

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: CARROLL
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WESTMINSTER
c. LENGTH OF STAY IN 1b: 10 YEARS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 147 PENNA AVE

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WESTMINSTER
d. STREET ADDRESS: 147 PENNA AVE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First BIRNIE Middle BOWERS Last HARMAN

4. DATE OF DEATH: Month FEBRUARY Day 24 Year 1967

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: MARCH 31 1897

9. AGE (In years last birthday): 69 yrs.

IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED, MILL WORKER, SO. STATES

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): CARROLL CO. MD.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: SAMUEL T. HARMAN

14. MOTHER'S MAIDEN NAME: IVA WILSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): —
(If yes give war or dates of service): —

16. SOCIAL SECURITY NO.: 215-26-0921

17. INFORMANT: MRS. BIRNIE B. HARMAN, Address SAME ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): CORONARY THROMBOSIS — INTERVAL BETWEEN ONSET AND DEATH: —

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE — 10 YEARS
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Febru, 1967, to Febru, 1967, that (I) (we) last saw the deceased alive on Feb 24 1967, and that death occurred at 7:30 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Daniel I Welliver M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2-24-67

22c. PHYSICIAN'S NAME (Type): DANIEL I. WELLIVER MD

22d. ADDRESS: WEST MINSTER MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 2/27/67

23c. NAME OF CEMETERY OR CREMATORY: EVERGREEN CEMETERY (MEM. GARDENS)

23d. LOCATION (City, town or county) (State): FINKSBURG, MD.

24. FUNERAL DIRECTOR: J. E. Myers Jr., Westminster, Md.

ADDRESS

25a. REC'D BY REGISTRAR DATE: FEB 28 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
15M 4-64

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02052 Items 8+9, Telephone Call - Jenkins 2/28/67 cc 02047

CERTIFICATE OF DEATH

1. PLACE OF DEATH
   a. COUNTY: Carroll — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Finksburg
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Sandy Mt. Rd.

2. USUAL RESIDENCE (Where deceased lived; If institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Baltimore
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Towson
   d. STREET ADDRESS: 1720 Aberdeen Rd.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Anna	Grason	Hill	2	28	1967

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
F	W		Oct. 12, 1883	83 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Homemaker		Balto. Co., Md.	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
William Grason	Anne S. P. Chew

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
No		Mrs. Ridgely H. Lee Finksburg, Md. Route #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Pulmonary edema	12 hrs.
DUE TO (b)	Arteriosclerotic C.V. Disease	years
DUE TO (c)		

4221

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from March 1, 19 64 to Feb. 28, 19 67, that (I) (we) last saw the deceased alive on Feb. 24 1967, and that death occurred at 10A M, from the causes and on the date stated above.

22a. SIGNATURE	M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22b. DATE SIGNED
Martin E. Strobel		2-28-67

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
Martin E. Strobel, M.D.	48 Main St. Reisterstown, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town or county) (State)
Burial	2-2-67	Prospect Hill	Towson Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
H.W. Jenkins & Sons Co.	4905 York Rd. Balto., Md.	MAR 1 1967	J. Charles Jones

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02053

CERTIFICATE OF DEATH

02048

1. **PLACE OF DEATH**
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Taneytown
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): Enroute to Hospital

2. **USUAL RESIDENCE** (Where deceosed lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL ond give neorest town): Rural Taneytown 06-1
d. STREET ADDRESS: Crouse Mill Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

99

3. NAME OF DECEASED (Type or print) First	Middle	Lost	4. DATE OF DEATH Month	Doy	Year
Charles	Howard	Hopkins	February	17	1967

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In yeors last birthdoy)	IF UNDER 1 YEAR Months	Doys	IF UNDER 24 HRS. Hours	Min.
Male	White		Nov. 13, 1899	67 yrs.				

10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & Stote, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Pharmacist	Pharmacy	Baltimore City, Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Harry M. Hopkins	Bertha Murray

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
No	212-07-8220A	Mrs. Linda G. Hopkins Taneytown, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (o)	Massive Coronary Occlusion	20 min
DUE TO (b)	Arterio-Sclerotic Cardio-Vascular Dis	7 yrs
DUE TO (c)	Generalized Arteriosclerosis	10 yrs

4201

Conditions, if ony, which gove rise to immediote couse (o), stoting the underlying couse lost.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)
Mod anemia, Cardiac Emargent.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

2

20o. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Yeor Hour o.m. p.m. 19	20d. INJURY OCCURRED While ot work ☐ Not While ot work ☐	20e. PLACE OF INJURY (Home, form, foctory, street, office bldg., etc.)	20f. (City or town) (County) (Stote)

21. **I certify** that (I) (this haspital) attended the deceased from Feb 12, 1961, to Feb 17, 1967 that (I) (we) last saw the deceased alive an Feb 17 1967, and that death accurred at 9:35 PM, fram causes and an the date stated abave.

22o. SIGNATURE	M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22b. DATE SIGNED
E. Ambler Thompson		Feb 19, 1967

22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS
E. Ambler Thompson	Taneytown, Maryland

1

23o. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (Stote)
Burial	2/21/67	Lutheran Cemetery	Taneytown, Carroll, Maryland

24. FUNERAL DIRECTOR ADDRESS	25o. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
John H. Skiles, C.O. Fuss & Son, Taneytown, Md.	FEB 21 1967	J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02054 02049

1. PLACE OF DEATH
a. COUNTY: Carroll Co. — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westminster RT#4
c. LENGTH OF STAY IN 1b: 3 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westminster RT#4 06-1
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First KATHLEEN Middle F. Last ISLIP

4. DATE OF DEATH: Month FEB Day 11 Year 1967

5. SEX: female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: APRIL 1 1885
9. AGE (In years last birthday): 81 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): home-wife
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (County & State, or foreign country): Manchester England
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Jack Fitzwilliam
14. MOTHER'S MAIDEN NAME: ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): —
(If yes give war or dates of service): —
16. SOCIAL SECURITY NO.: ?
17. INFORMANT: Mrs. Mahala Roscoe Address: Same address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebrovascular accident — INTERVAL BETWEEN ONSET AND DEATH: 4 days
331X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Influenza
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

2Da. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
2Dc. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
2Dd. INJURY OCCURRED While at work ☐ Not While at work ☐
2De. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
2Df. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Mar 3, 1962, to Feb 11, 1967, that (I) (we) last saw the deceased alive on Feb 10 1967, and that death occurred at 6:45 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Julius Chepko — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 2/11/67
22c. PHYSICIAN'S NAME (Type): Julius Chepko
22d. ADDRESS: 854 W Green St Westminster Md

23a. BURIAL, CREMATION, REMOVAL (Specify): ~~Burial~~ Removal 2/11/67
23b. DATE THEREOF
23c. NAME OF CEMETERY OR CREMATORY: Oakwood Cemetery
23d. LOCATION (City, town or county) (State): Richmond Va.

24. FUNERAL DIRECTOR ADDRESS: J. E. Snyder Jr., Westminster, Md.
25a. REC'D BY REGISTRAR DATE: FEB 14 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
2DM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02055

CERTIFICATE OF DEATH

02050

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Manchester
c. LENGTH OF STAY IN 1b: 2 weeks
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Long View Nursing Home Inc

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westminster, Md — 06-1
d. STREET ADDRESS: 601 old Baltimore Blvd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Grace — Middle: Brown — Last: Jackson

4. DATE OF DEATH: Month: Feb — Day: 11 — Year: 1967

5. SEX: female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 28 - 1888

9. AGE (In years last birthday): 78 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Carroll Co, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George Richard Brown

14. MOTHER'S MAIDEN NAME: Sophia Kruck

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 216-05-1309

17. INFORMANT: Marion Redmile — Address: 17 Shirley Rd Manbarth, Pa

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebro Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 2 days
4221
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerotic Cardio-Vascular Disease — 5 yrs
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1/28, 1967, to 2/11, 1967, that (I) (we) last saw the deceased alive on 2/10/1967, and that death occurred at 9:30 AM, from the causes and on the date stated above.

22a. SIGNATURE: W H Foard — M.O. ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2/11/67

22c. PHYSICIAN'S NAME (Type): W. H Foard M.D.

22d. ADDRESS: Manchester, Md. 21102

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2/14/67

23c. NAME OF CEMETERY OR CREMATORY: Westminster Cemetery

23d. LOCATION (City, town or county) (State): Westminster, Md.

24. FUNERAL DIRECTOR: J. S. Myers Jr. — ADDRESS: Westminster, Md.

25a. RECD BY REGISTRAR DATE: FEB 14 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02056

CERTIFICATE OF DEATH

02051

1. PLACE OF DEATH
a. COUNTY: CARROLL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): NEW WINDSOR
c. LENGTH OF STAY IN 1b: YEARS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

2. USUAL RESIDENCE (Where deceased lived, if institution—Residence before admission)
a. STATE: MARYLAND — b. COUNTY: CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): NEW WINDSOR
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOHN — Middle HERBERT — Last JACKSON, SR

4. DATE OF DEATH: Month JAN — Day 9, — Year 1967

5. SEX: MALE

6. COLOR OR RACE: COL

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: MAR 23-1883

9. AGE (In years last birthday): 83 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER

10b. KIND OF BUSINESS OR INDUSTRY: GENERAL

11. BIRTHPLACE (County & State, or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: JOHN JACKSON

14. MOTHER'S MAIDEN NAME: MARY THOMPSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 214-16-0080

17. INFORMANT: MRS. OLIVIA JACKSON — Address: NEW WINDSOR MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic C.V.D.
DUE TO
(b)
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1/13, 1967, to 2/9, 1967, that (I) ~~(we)~~ last saw the deceased alive on 1/26 1967, and that death occurred at 1:35 A M, from causes and on the date stated above.

22a. SIGNATURE: M.E. Robertson — M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☒ STAFF PHYS. ☐

22b. DATE SIGNED: 2/9/67

22c. PHYSICIAN'S NAME (Type): M.E. ROBERTSON

22d. ADDRESS: NEW WINDSOR, MD

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 2-12-67

23c. NAME OF CEMETERY OR CREMATORY: MT OLIVE CEM.

23d. LOCATION (City or Town) (County) (State): FREDERICK COUNTY MD

24. FUNERAL DIRECTOR — ADDRESS: O.D. Hartzler & Sons NEW WINDSOR MD

25a. REC'D BY REGISTRAR DATE: FEB 14 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Jones

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 16 Film G385 2/15/67 mh

CERTIFICATE OF DEATH

02057 02052

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Carroll
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural--Sykesville
c. LENGTH OF STAY IN 1b: 33yr. 27days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Talbot
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Queen Anne
d. STREET ADDRESS: --
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: SARAH (Sallie) Middle: BARTON Last: Jump

4. DATE OF DEATH: Month: 2 Day: 8 Year: 1967

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 11/30/78
9. AGE (In years last birthday): 88 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ~~unknown~~ FRANCIS Tatum BARTON
14. MOTHER'S MAIDEN NAME: ~~unknown~~ SARAH Josephine MORGAN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give wor or dotes of service)
16. SOCIAL SECURITY NO. 220-44-5601 220-54-7729
17. INFORMANT Address: Springfield Hospital records, Sykesville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac failure
DUE TO
(b): Myocardial infarction
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH: hours / days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Paranoia.
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1/11/, 1934, to 2/8/, 1967, that (I) (we) last saw the deceased alive an 2/8/ 1967, and that death accurred at 5:15a M, from causes and an the date stated abave.

22a. SIGNATURE: Ed Reeves MD M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 2/8/67
22c. PHYSICIAN'S NAME (Type): Edmee J. Reeves, M. D.
22d. ADDRESS: Springfield State Hospital Sykesville, Maryland

23a. BURIAL, ~~CREMATION~~, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: FEB. 10, 1967
23c. NAME OF CEMETERY OR CREMATORY: GREENMOUNT CEMETERY
23d. LOCATION (City or Town) (County) (State): Hillsboro Caroline Co. Md.

24. FUNERAL DIRECTOR: James H. Barton Jr. ADDRESS: Barton Bros, Centreville, Md. 21617
25a. REC'D BY REGISTRAR DATE: FEB 14 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02058 Item 6 Film G385 2/14/67 mh 02053

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. **PLACE OF DEATH**
a. COUNTY: CARROLL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): MANCHESTER
c. LENGTH OF STAY IN 1b: 4 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Longview Nursing Home

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: MD PA. — b. COUNTY: ~~Harford~~ ~~BALTIMORE~~ Co.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Stewarts Town, Pa. 75-3
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. **NAME OF DECEASED** (Type or print): First GRACE — Middle ELEANOR — Last LANHAM
4. **DATE OF DEATH**: Month 2 — Day 3 — Year 1967
5. SEX: FEMALE
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: NOV. 5 1891 1890
9. AGE (In years last birthday): 76 yrs. — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Baltimore Co. Md Worthington Valley
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Jacob Harris
14. MOTHER'S MAIDEN NAME: ELEANOR Combs
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.: 218-32-4301B
17. INFORMANT — Address: EARL LANHAM

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Cerebral Thrombosis	24 hrs.
DUE TO (b)	Complete - Heart Block & Stokes-Adams Syndrome	3-4 years
DUE TO (c)	General Arteriosclerosis	Unknown

4330

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1-30, 1966 to 2-3, 1967, that (I) (we) last saw the deceased alive on 2-3 19 67, and that death occurred at 7:00 PM, from the causes and on the date stated above.

22a. SIGNATURE: Maurice C. Porterfield M.D.
ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 2-4-67
22c. PHYSICIAN'S NAME (Type): M.C.Porterfield
22d. ADDRESS: Hampstead, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 2/6/67
23c. NAME OF CEMETERY OR CREMATORY: MT Zion
23d. LOCATION (City, town or county) (State): Balto Co Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Tipton Eline Funeral — ADDRESS: Home Hampstead
25a. REC'D BY REGISTRAR DATE: FEB 8 1967
25b. REGISTRAR'S SIGNATURE: Juliette Judge

VR A15 (4) 1SM 7-62

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02059

CERTIFICATE OF DEATH

02054

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. **PLACE OF DEATH**
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Rural-Finksburg
c. LENGTH OF STAY IN 1b: 21 Years
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Route 1

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural-Finksburg
d. STREET ADDRESS: Route 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First CLARENCE Middle A. Last LINDSAY

4. **DATE OF DEATH**: Month February Dey 9, Year 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct. 17, 1906

9. AGE (In years last birthday): 60 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinist

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Carroll Co., Md.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Albert S. Lindsay

14. MOTHER'S MAIDEN NAME: Bertie A. Young

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give wer or dates of service):

16. SOCIAL SECURITY NO.: 214-03-0575

17. **INFORMANT** Address: Mrs. Mary L. Lindsay Same As #2

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs

DUE TO (b): Cerebral disturbance (stroke) — 4 mos

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Virus Viral infection (Pneumonia) — 2 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(c)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Dey, Yeer 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (~~this hospital~~) attended the deceased from Feb 7, 1967 to Feb 9, 1967, that (I) (~~we~~) last saw the deceased alive on Feb 8, 1967, and that death occurred at 1:10 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Wm C. Jennette M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2-9-67

22c. PHYSICIAN'S NAME (Type): Wm Carl Jennette

22d. ADDRESS: 105 E Main Westminster Md

23e. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2/12/1967

23c. NAME OF CEMETERY OR CREMATORY: Deer Park Cemetery

23d. LOCATION (City, town or county) (State): Carroll Co., Md.

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: C. M. Waltz Box 241 Sykesville, Md.

25a. REC'D BY REGISTRAR DATE: FEB 14 1967

25b. REGISTRAR'S SIGNATURE: J Charles Judge

VR A1S (4)
20M 5-63

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02060

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02055

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: CARROLL
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WESTMINSTER
   c. LENGTH OF STAY IN 1b: 18 YRS.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 56 JOHN ST.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: MARYLAND
   b. COUNTY: CARROLL
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WESTMINSTER
   d. STREET ADDRESS: 56 JOHN ST.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LILLY Middle MAY Last LINTON

4. DATE OF DEATH: Month 2 Day 6 Year 1967

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: MARCH 29 1895

9. AGE (In years last birthday): 71 yrs.
   IF UNDER 1 YEAR: Months ___ Days ___
   IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): DOMESTIC

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): FREDERICK, MD

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: LOUIS B. LINTON

14. MOTHER'S MAIDEN NAME: LIZZIE POOLE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): —
    (If yes give war or dates of service): —

16. SOCIAL SECURITY NO.: 218-54-2450

17. INFORMANT: JANE IBEX, Address: SAME ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis (acute) — INTERVAL BETWEEN ONSET AND DEATH: Sudden

4201

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): —
DUE TO (c): —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Wyleen Speicher M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type)

Address (Street, town) (County)

22. DATE SIGNED: 2-6-67

135 E. Main, Westminster, Carroll, Md. (State)

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 2/8/67

23c. NAME OF CEMETERY OR CREMATORY: CARROLL CO. HOME CEM.

23d. LOCATION (City, town or county): RURAL, WESTMINSTER MD.

24. FUNERAL DIRECTOR: J. E. Myers, Jr. ADDRESS: Westminster, Md.

25a. REC'D BY REGISTRAR DATE: FEB 9 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15ME
350D 4-64

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02061 02056

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): HAMPSTEAD Rural
c. LENGTH OF STAY IN 1b: 3 years
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Fairmount Road.

2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission)
a. STATE: Maryland b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAMPSTEAD Mary Land 06-1
d. STREET ADDRESS: FAIRMOUNT ROAD.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First VERONICA Middle M. Last MILHIMES

4. DATE OF DEATH: Month February Day 23 Year 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: October 29 1874
9. AGE (In years last birthday): 92 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (County & State, or foreign country): Little Tower PA.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Anthony Smith
14. MOTHER'S MAIDEN NAME: Catherine L Hemler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.: 160-38-1620
17. INFORMANT: Address: Mrs Rudita Fredrick, HAMPSTEAD Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 4221
DUE TO (b): Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: ?
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Arteriosclerotic Cardiovascular Disease — ?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Jan 12, 1966 to Febru 23, 1967, that (I) (we) last saw the deceased alive on Febru 21 19 67, and that death occurred at 10:30 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Joseph E Bush M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 2-23-67
22c. PHYSICIAN'S NAME (Type): Joseph E. Bush MD
22d. ADDRESS: HAMPSTEAD Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Feb. 26, 1967
23c. NAME OF CEMETERY OR CREMATORY: Pines Church Cemetery
23d. LOCATION (City, town or county) (State): Adams Co. Straban Twp Pa.

24 FUNERAL DIRECTOR'S SIGNATURE: Russell M. Heiser
ADDRESS: New Oxford, Pa.
25a. REC'D BY REGISTRAR DATE: FEB 28 1967
25b. REGISTRAR'S SIGNATURE: J Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7-62

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02062 Item 9 Film G385 2/14/67 mh

CERTIFICATE OF DEATH

02057

1. PLACE OF DEATH — a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Taneytown
c. LENGTH OF STAY IN 1b: 20 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): W. Baltimore Street

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) — a. STATE: Maryland — b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Taneytown, Md.
d. STREET ADDRESS: W. Baltimore Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: George — Middle: Wilbur — Last: Naylor, Sr.

4. DATE OF DEATH: Month: February — Day: 7 — Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept. 9, 1901

9. AGE (In years last birthday): 66/65 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (County & State, or foreign country): Frederick Co., Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George C. Naylor

14. MOTHER'S MAIDEN NAME: Maude Estelle Stull

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give wor or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — Address: Mrs. Ruth Naylor, W. Balto. St., Taneytown, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Instantaneous
DUE TO
(b): Coronary Insufficiency — 2-3 yrs
DUE TO
(c): Arterio-Sclerotic Heart Disease — 3 yrs +

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): Heart Failure Chronic, Osteoarthritis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Yeor Hour o.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Have not attended but Talked to Family Dr. saw the deceased alive on Feb 1 19 67, and that death occurred at 11:10 AM, from causes and on the date stated above.

22a. SIGNATURE: E. Ambler Thompson M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒ — 22b. DATE SIGNED: 2/8/67

22c. PHYSICIAN'S NAME (Type): E. AMBLER THOMPSON — 22d. ADDRESS: TANEYTOWN, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 2/10/67 — 23c. NAME OF CEMETERY OR CREMATORY: Keysville Cemetery — 23d. LOCATION (City or Town) (County) (State): Keysville, CarrollCo., Md.

24. FUNERAL DIRECTOR — ADDRESS: C.O. Fuss & Son Taneytown, Md. John H. Skiles

25a. REC'D BY REGISTRAR DATE: FEB 10 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02063 02058

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7-62

1. **PLACE OF DEATH**
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Manchester
c. LENGTH OF STAY IN 1b: 3yrs 2 Mos
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Long View Nursing Home

2. **USUAL RESIDENCE** (Where deceased lived, If institution, Residence before admission)
e. STATE: Maryland
b. COUNTY: Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 3105 Rolling Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Elizabeth — Middle: R. — Last: Piel

4. **DATE OF DEATH**: Month: February — Day: 1 — Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Dec 30, 1874

9. AGE (In years last birthday): 92 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (County & State, or foreign country): Baltimore County, Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William Sellers

14. MOTHER'S MAIDEN NAME: Mary J. Coates

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): No

16. SOCIAL SECURITY NO.: 217-03-1833

17. INFORMANT: Carroll Piel, 5519 Gwynn Oak Ave — Address: Balt Md

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Chronic Myocarditis
DUE TO (b): Arterio-Sclerotic Cardiovascular Disease
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: ?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year — 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1-3- 1962 to 2-1 1967, that (I) (we) last saw the deceased alive on January 31 1967, and that death occurred at 1:30 P.M. from the causes and on the date stated above.

22e. SIGNATURE: Joseph E. Bush MD M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2/1/67

22c. PHYSICIAN'S NAME (Type): Joseph E. Bush MD

22d. ADDRESS: Hampstead Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2-4-1967

23c. NAME OF CEMETERY OR CREMATORY: Mt. Olive Cemetery

23d. LOCATION (City, town or county) (State): Randallstown, Md

24 FUNERAL DIRECTOR'S SIGNATURE: Lorny Byers

ADDRESS: 8728 Liberty Road

25a. REC'D BY REGISTRAR DATE: 2 6 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 2 Film G385 2/14/67 mh

02064

CERTIFICATE OF DEATH

02059

1. PLACE OF DEATH
a. COUNTY: Carroll County — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville, Maryland
c. LENGTH OF STAY IN 1b: 9mons. 29 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville — Baltimore
d. STREET ADDRESS: 3220 Carlisle Ave. Springfield State Hospital
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Louise	May	Pirie	February	5	1967

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	NEVER MARRIED ☒	7-31-78	88 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Beautician		Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Henry J. Pirie	Isabel McCoy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
No	216-05-1215	Hospital Records.	Sykesville, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Natural death — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(b): CBS ass't senile brain disease with psychotic reaction
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
304X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. I certify that (I) (this hospital) attended the deceased from 4-7-66, 1966, to 2-5-, 1967, that (I) (we) last saw the deceased alive on 2-4- 1967, and that death occurred at 3:15A M, from causes and on the dote stated abave.

22a. SIGNATURE: Luis F. Casal, M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 2-5-67
22c. PHYSICIAN'S NAME (Type): Dr. Casal
22d. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	2/9/1967	Loudon Park Cemetery	Baltimore, Maryland

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Wm. J. Wilson & Sons North Ave. Balto. Md.	FEB 6 1967	J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02065

CERTIFICATE OF DEATH

02060

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal. And in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westminster,
c. LENGTH OF STAY IN 1b: 2 hours
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Carroll Co. General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westminster
d. STREET ADDRESS: 64½ Winchester Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Charles — Middle: Luther — Last: Pittinger

4. DATE OF DEATH: Month: February — Day: 27 — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: October 6, 1892

9. AGE (In years last birthday): 74 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Frederick County, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Samuel B. Pittinger

14. MOTHER'S MAIDEN NAME: May Winter

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 212-14-6789

17. INFORMANT: Address: 64½ Winchester Ave.
Mrs. Lillie Pittinger, Westminster, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 332X
DUE TO (b): Cerebral Thrombosis — several hours
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Feb 27, 19 67, to Feb 27, 19 67, that (I) (we) last saw the deceased alive on Feb 27, 19 67, and that death occurred at 11:45 M, from causes and on the date stated above.

22a. SIGNATURE: John S. Harsha M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2/27/67

22c. PHYSICIAN'S NAME (Type): JOHN S. HARSHA M.D

22d. ADDRESS: Gaulon St. Westminster, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: ~~Feb~~ Mar. 2, 1967

23c. NAME OF CEMETERY OR CREMATORY: Winters Cemetery

23d. LOCATION (City or Town) (County) (State): Linwood, Carroll, Maryland

24. FUNERAL DIRECTOR: John H. Skiles
ADDRESS: C.O. Fuss & Son (John H. Skiles) Taneytown, Maryland

25a. REC'D BY REGISTRAR DATE: MAR 1 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02066

CERTIFICATE OF DEATH

02061

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: Carroll
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Manchester, Md.
   c. LENGTH OF STAY IN 1b: 4 mo - 2 wks
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Longview Nursing Home Inc. 128 W Main St.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
   a. STATE: Md
   b. COUNTY: Carroll
   c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Westminster, Md.
   d. STREET ADDRESS: 138 E Main St Westminster Md
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Wivie; Middle: Margaret; Last: Poirel

4. DATE OF DEATH: Month: 2; Day: 27; Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Nov 4, 1888

9. AGE (In years last birthday): 78 yrs.
   IF UNDER 1 YEAR: Months ____ Days ____
   IF UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: ____

11. BIRTHPLACE (County & State, or foreign country): Carroll Co on farm

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Thomas Ward

14. MOTHER'S MAIDEN NAME: Margaret Ann Hamilton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
   (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 213-05-1728

17. INFORMANT: Margaret Lovey (Friend daughter) Address: RFD #7 Westminster Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Broncho-pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1 wk

Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.

DUE TO (b): Arteriosclerotic cardio Vascular Disease — 5 yrs

DUE TO (c): Diabetes Mellitus — 5 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year; Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) this hospital attended the deceased from Oct 15, 1966, to Feb 27, 1967, that (I) (we) last saw the deceased alive on 2/26 1967, and that death occurred at 1p M, from the causes and on the date stated above.

22a. SIGNATURE: W. H Foard M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2/27/67

22c. PHYSICIAN'S NAME (Type): WH Foard M.D

22d. ADDRESS: Manchester, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3/2/67

23c. NAME OF CEMETERY OR CREMATORY: Sandymount Cemetery

23d. LOCATION (City, town or county) (State): Finksburg RD #1 Md.

24. FUNERAL DIRECTOR: J. E. Myers Jr., Westminster, Md ADDRESS

25a. REC'D BY REGISTRAR DATE: MAR 2 1967

25b. REGISTRAR'S SIGNATURE: J Charles Judge

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02067

CERTIFICATE OF DEATH

02062

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 43yrs.1mo.13dys.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporote limits, write RURAL and give neorest town): Baltimore
d. STREET ADDRESS: 12 S. Greene St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WILLIAM — Middle (NMN) — Lost RADESKY

4. DATE OF DEATH: Month FEBRUARY — Doy 18 — Year 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April, 1894

9. AGE (In years lost birthdoy) yrs.: 72

IF UNDER 1 YEAR: Months — Doys
IF UNDER 24 HRS.: Hours — Min.

10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Factory Hand

10b. KIND OF BUSINESS OR INDUSTRY: Employee

11. BIRTHPLACE (County & Stote, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Israel Radesky

14. MOTHER'S MAIDEN NAME: Esther Cohen

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service): No

16. SOCIAL SECURITY NO.: 220-54-6659

17. INFORMANT Address: Records, Springfield State Hospital

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), ond (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: Days
491X
DUE TO
Conditions, if ony, which gave rise to immediote couse (o), stoting the underlying couse last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o): Schizophrenic reaction, hebephrenic type

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20o. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Doy, Yeor Hour a.m. p.m. 19

20d. INJURY OCCURRED While ot work ☐ Not While ot work ☐

20e. PLACE OF INJURY (Home, form, foctory, street, office bldg., etc.)

20f. (City or town) (County) (Stote)

21. **I certify** that (I) (this hospital) attended the deceased from 1-5-24, 19, to 2-18-67, 19, that (I) (we) last saw the deceased alive on 2-18-67, 19, and that death occurred at 1:30 PM, from causes and on the date stated above.

22o. SIGNATURE: Agustin del Campo. M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 2-20-67

22c. PHYSICIAN'S NAME (Type): Agustin del Campo, M. D.

22d. ADDRESS: Springfield State Hospital, Sykesville, Maryland

23o. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2/22/67

23c. NAME OF CEMETERY OR CREMATORY: Rodfe Zedek

23d. LOCATION (City or Town) (County) (Stote): Baltimore, Maryland

24. FUNERAL DIRECTOR ADDRESS: Sol Levinson & Bros. Inc., 6010 Reist., Rd.

25o. REC'D BY REGISTRAR DATE: FEB 24 1967

25b. REGISTRAR'S SIGNATURE: J Charles Jenega

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02068

CERTIFICATE OF DEATH

02063

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 18 dys.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore City
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 2926 Harford Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
ROSE	(NMN)	REHLING	FEBRUARY	22	19 67

5. SEX	6. COLOR OR RACE	7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	White	WIDOWED ☒	11-25-1886	80 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	--	Maryland	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John Meyer	Mary Unclebach

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
No	Unk.	Records, Springfield State Hospital

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
163X
IMMEDIATE CAUSE (a): Carcinoma of the left lung with metastasis to the liver — INTERVAL BETWEEN ONSET AND DEATH: months
DUE TO (b): Acute embolism, right lung — hours
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 2-4-67, 19__, to 2-22-67, 19__, that (I) (we) last saw the deceased alive on 2-22-67 19__, and that death occurred at 5:05 P.M. from causes and on the date stated above.

22a. SIGNATURE: Dr. Antonius Glahn — M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 2-23-67
22c. PHYSICIAN'S NAME (Type): Antonius Glahn, M. D.
22d. ADDRESS: Springfield State Hospital Sykesville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	2-28-1967	Western	Baltimore, Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
G.Howard Strong 3207 W. North Ave.,	FEB 27 1967	J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

02069 — Reg. Dist. No. 02064

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Union Bridge
c. LENGTH OF STAY IN 1b: 4 Years
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Horton Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Howard
c. CITY OR TOWN (If outside corporote limits, write RURAL and give nearest town): Ellicott City
d. STREET ADDRESS: ----
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Ernest — Middle Abby — Last Ridgely

4. DATE OF DEATH: Month Feb. — Day 16, — Year 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Oct. 19, 1900

9. AGE (In years last birthday): 66 yrs.
IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Edward Ridgely

14. MOTHER'S MAIDEN NAME: Catherine Burns

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): ------

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Forrest Peddicord — Address: Marriottsville, M

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic C.V.D.
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):

INTERVAL BETWEEN ONSET AND DEATH: years

4221

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 5/11/61, 19____, to 2/14, 1967, that I last saw the deceased alive on 2/14/67, 19____, and that death occurred at 7 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: M. E. Robertson M.D. — ADDRESS (Street, city or town, state): New Windsor, Md. — DATE SIGNED: 2/14/67

PHYSICIAN'S NAME (Type): M. E. Robertson

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 2-18-67
22c. NAME OF CEMETERY OR CREMATORY: St. John's Cemetery
22d. LOCATION (City, town, or county) (State): Ellicott City, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Harry W. Knight — ADDRESS: Sykesville, Md.

24a. REC'D BY REGISTRAR DATE: FEB 20 1967

24b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02070

CERTIFICATE OF DEATH

02065

1. **PLACE OF DEATH**
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Middleburg
c. LENGTH OF STAY IN 1b: 4 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Brookfield Manor Nursing Home

2. **USUAL RESIDENCE** (Where deceased lived, If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural Taneytown 06-1
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Gertie — Middle: May — Last: Ridinger

4. **DATE OF DEATH**: Month: February — Day: 21, — Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept. 11, 1887

9. AGE (In years last birthday): 79 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Carroll Co. Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Ridinger

14. MOTHER'S MAIDEN NAME: Clara Shoemaker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: Vern H. Ridinger RFD, Taneytown, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Generlyzd atherosclerosis — INTERVAL BETWEEN ONSET AND DEATH: Years.
4500
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Parkinson's Syndrome due to atherosclerosis — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 3/2/67, 19..., to 2/21/67, 19..., that (I) (we) last saw the deceased alive on 2/16/67, 19..., and that death occured at 1:45 P.M., from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2/21/67

22c. PHYSICIAN'S NAME (Type): J.H. Caricofe

22d. ADDRESS: Union Bridge, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2/23/67

23c. NAME OF CEMETERY OR CREMATORY: United Brethern Cemetery

23d. LOCATION (City, town or county) (State): Taneytown, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: John H. Skiles C.O. Fuss & Son, Taneytown, Md.

25a. REC'D BY REGISTRAR — DATE: FEB 23 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02071

CERTIFICATE OF DEATH

02066

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Manchester Md
c. LENGTH OF STAY IN 1b: 4 mths
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Long View Nursing Home

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Penna. — b. COUNTY: Adams
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fairfield
d. STREET ADDRESS: RFD 2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Margaret — Middle: Alice — Last: Riley

4. DATE OF DEATH: Month: Feb — Day: 17 — Year: 1967

5. SEX: female

6. COLOR OR RACE: White

7. MARRIED ☑ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: April 20 1887

9. AGE (In years last birthday): 79 yrs.

IF UNDER 1 YEAR: Months | Days — IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Frederick Co, Md

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: James Martin

14. MOTHER'S MAIDEN NAME: Margaret Ballinger

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No

16. SOCIAL SECURITY NO.: 186-03-5601

17. INFORMANT: Ray D Riley — Address: 8 Pinehill Rd Westminster, Md

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebro Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 6 days
DUE TO (b): Generalized Arteriosclerosis — 5 yrs
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Dey, Year 19 — 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 12/21, 1966, to 2/17, 1967, that (I) (we) last saw the deceased alive on 2/17, 1967, and that death occurred at 3:30 PM from the causes and on the date stated above.

22a. SIGNATURE: W H Foard M.D. — ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): W H Foard MD — 22d. ADDRESS: Manchester, Md 2/17/67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: Feb. 20, 1967 — 23c. NAME OF CEMETERY OR CREMATORY: Fairfield Union — 23d. LOCATION (City, town or county) (State): Fairfield, Adams Co. Pa.

24 FUNERAL DIRECTOR'S SIGNATURE: Clarence E. Wilson — ADDRESS: Emmitsburg, Md. — 25e. REC'D BY REGISTRAR DAT FEB 21 1967 — 25b. REGISTRAR'S SIGNATURE: Charles Judge

Clarence E. Wilson

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 7-62

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02072

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02067

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Woodbine
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Woodbine 06-1
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: VERNON — Middle: McKINLEY (Mc) — Last: RIPPEON
4. DATE OF DEATH: Month: February — Day: 23, — Year: 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Sept. 29, 1891
9. AGE (In years last birthday): 75 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Carroll Co., Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George W. Rippeon
14. MOTHER'S MAIDEN NAME: Mary Catherin e Foreman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes (If yes give war or dates of service): WW 1
16. SOCIAL SECURITY NO.: 227-20-1019
17. INFORMANT: Manley Reid Rippeon — Address: Same As #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Thrombosis (Acute) — INTERVAL BETWEEN ONSET AND DEATH: Short Time
4201
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b): — DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: W Glenn Speicher M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): W. Glenn Speicher
Address (Street, No., town or county): 1325 E. Main St. Westminster Carroll (State)

22. DATE SIGNED: 2-23-67

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 2/27/1967
23c. NAME OF CEMETERY OR CREMATORY: Morgan Chapel
23d. LOCATION (City, town or county): Carroll Co., Md.

24. FUNERAL DIRECTOR — ADDRESS: C. M. Waltz Box 241 Sykesville, Md.
25a. REC'D BY REGISTRAR DATE: FEB 28 1967
25b. REGISTRAR'S SIGNATURE: J Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
3500 4-64

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02073

CERTIFICATE OF DEATH

02068

1. **PLACE OF DEATH**
   a. COUNTY: Carroll — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Finksburg
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): R.D. 1

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Md. — b. COUNTY: Carroll
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Finksburg
   d. STREET ADDRESS: R.D. 1
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Anita — Middle: A. — Last: Roberts

4. **DATE OF DEATH**: Month: Feb. — Day: 26, — Year: 19 67

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 7, 1899

9. AGE (In years last birthday): 67 yrs.
   IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Carroll Co. Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Henry Lessner

14. MOTHER'S MAIDEN NAME: Elizabeth Miller

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 212-05-7388B

17. **INFORMANT**: John H. Roberts — Address: Finksburg, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 5 min
DUE TO (b): Arteriosclerotic Heart Disease — 3 yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from June, 19 66, to Feb 26, 19 67 that (I) (we) last saw the deceased alive on Jan., 19 67, and that death occurred at 4:15 M, from causes and on the date stated above.

22a. SIGNATURE: D.A. Knight — M.D. ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED:

22c. PHYSICIAN'S NAME (Type): D.A. Knight MD.

22d. ADDRESS: Greenmount, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 3/1/67

23c. NAME OF CEMETERY OR CREMATORY: Immuneal Cemetery

23d. LOCATION (City or Town) (County) (State): Manchester Carroll, Md.

24. FUNERAL DIRECTOR — ADDRESS: Tipton - Eline Funeral Home Hampstead, Md.

25a. REC'D BY REGISTRAR — DATE: MAR 1 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02074

CERTIFICATE OF DEATH

02069

1. PLACE OF DEATH
a. COUNTY: CARROLL Co. — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): RURAL, WESTMINSTER
c. LENGTH OF STAY IN 1b: 86 YRS.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): POOL ROAD RD#4

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL, WESTMINSTER, RD#4 06
d. STREET ADDRESS: POOL ROAD
e. IS RESIDENCE ON A FARM? YES ☑ NO ☐

3. NAME OF DECEASED (Type or print): First LESLIE Middle CLINTON Last ROBERTSON

4. DATE OF DEATH: Month FEB Day 10 Year 1967

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: JAN. 4, 1881

9. AGE (In years last birthday): 86 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RURAL MAIL CARRIER

10b. KIND OF BUSINESS OR INDUSTRY: RETIRED

11. BIRTHPLACE (County & State, or Foreign country): CARROLL CO. MD

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: GEORGE ROBERTSON

14. MOTHER'S MAIDEN NAME: RACHEL HOOK

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) — (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: —

17. INFORMANT: G. EDWIN ROBERTSON — Address: 134 East Main St. Westminster Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): MYOCARDIAL INFARCTION — INTERVAL BETWEEN ONSET AND DEATH: 3 HOURS
4201
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): ARTERIOSCLEROSIS — 10 YRS
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): DIABETES MELLITUS 5-6 YEARS

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from JAN. , 1963, to FEB. 10, 1967, that (I) (we) last saw the deceased alive on FEB. 10 1967, and that death occurred at 7.30 AM, from the causes and on the date stated above.

22a. SIGNATURE: William J. Stewart, M.D. — ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2/10/67

22c. PHYSICIAN'S NAME (Type): WILLIAM L. STEWART

22d. ADDRESS: 19 RIDGE RD. WESTMINSTER, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 2/13/67

23c. NAME OF CEMETERY OR CREMATORY: WESTMINSTER CEMETERY

23d. LOCATION (City, town or county) (State): WESTMINSTER, MD

24. FUNERAL DIRECTOR — ADDRESS: J. E. Myers, Jr., WESTMINSTER, MD

25a. REC'D BY REGISTRAR DATE: FEB 14 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02075

CERTIFICATE OF DEATH

02070

1. **PLACE OF DEATH**
   a. COUNTY: Carroll — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
   c. LENGTH OF STAY IN 1b: 22yrs.7mos.12dys.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Springfield State Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Baltimore County
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sparrows Point
   d. STREET ADDRESS: 2916 Salisbury Ave.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
ERNEST	WILHO	ROSE	FEBRUARY	9	19 67

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White		1-14-05	62 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Machinist		Pennsylvania	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Axel Rose	Rosa (last name unk.)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
No	167-03-2781	Records, Springfield State Hospital

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Acute peritonitis	Day
DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying couse last. (b)	Perforated duodenal ulcer	Days
DUE TO (c)	Gangrene of right leg due to arteriosclerosis	Months & Years

5411 0251

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
CBS with CNS syphilis, meningoencephalitic, with psychotic reaction

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Not While at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 6-27-44, 19__, to 2-9-67, 19__, that (I) (we) last saw the deceased alive on 2-9-67 19__, and that death occurred at 1:12 M, from causes and on the date stated above.

22a. SIGNATURE: Octavio A Ruiz — M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 2-9-67

22c. PHYSICIAN'S NAME (Type): Octavio A. Ruiz, M. D.

22d. ADDRESS: Springfield State Hospital, Sykesville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	2-16-67	Freedom Cemetery	Sykesville Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Harry W. Haight	Sykesville, Md.	FEB 20 1967	Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02076

CERTIFICATE OF DEATH

02071

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. **PLACE OF DEATH**
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westminster
c. LENGTH OF STAY IN 1b: 2 weeks
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Carroll County General Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Finksburg
d. STREET ADDRESS: Niner Rd.
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. **NAME OF DECEASED** (Type or print): First: John — Middle: Charles — Last: Ross

4. **DATE OF DEATH**: Month: 2 — Day: 23 — Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: Oct. 4, 1893

9. AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): St. Car Conductor

10b. KIND OF BUSINESS OR INDUSTRY: Balto. Transit

11. BIRTHPLACE (County & State, or foreign country): Baltimore Co., Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John B. Ross

14. MOTHER'S MAIDEN NAME: Marguerite Burns

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 216-12-0861

17. **INFORMANT**: Mrs. Sylvia T. Ross — Address: Niner Rd., Finksburg, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CIRCULATORY FAILURE — INTERVAL BETWEEN ONSET AND DEATH: DAYS
DUE TO
(b): ARTERIOSCLEROTIC HEART DISEASE - DECOMPENSATED — WEEKS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
~~DUE TO~~
~~(c)~~

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): BRONCHO PNEUMONIA

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 2/18, 1967 to 2/23, 1967, that (I) (we) last saw the deceased alive on 2/23 1967, and that death occurred at 11:33 M, from causes and on the date stated above.

22a. SIGNATURE: Vincent J. Fusco Jr. M.D. — ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22b. DATE SIGNED: 2/23/67

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2/25/67

23c. NAME OF CEMETERY OR CREMATORY: Evergreen Mem. Gardens

23d. LOCATION (City or Town) (County) (State): Finksburg, Carroll, Md.

24. FUNERAL DIRECTOR: H. J. Eckhardt — ADDRESS: Owings Mills, Md.

25a. REC'D BY REGISTRAR: DATE FEB 27 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Jones

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02077 Item #8 Film #1385 2/20/67 pc 02072

1. PLACE OF DEATH
a. COUNTY Carroll MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Woodbine
c. LENGTH OF STAY IN 1b Years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route 97

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE Md. b. COUNTY Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Woodbine 06-1
d. STREET ADDRESS Route 97
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: James Middle: HARRIS Last: SANNER, SR.

4. DATE OF DEATH Month: Feb. Day: 10, Year: 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 14, 1895 1894

9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR Months / Days; IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Office Manager

10b. KIND OF BUSINESS OR INDUSTRY: Drugs

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George R. SANNER

14. MOTHER'S MAIDEN NAME: LAURA MACKEY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT Address: MR. Harris SANNER, JR. - Woodbine, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Infarction of Coronary Artery — INTERVAL BETWEEN ONSET AND DEATH: few min.
4201
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.
DUE TO (b): Chronic Hypertensive Cardiovascular
DUE TO (c): Disease — 15+ yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year / Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1965, 19___, to 10/Feb/67 19___, that (I) (we) last saw the deceased alive on 10/Feb/67 19___, and that death occurred at 1 P M, from the causes and on the date stated above.

22a. SIGNATURE: Wm. H. Lawson M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Wm. H. Lawson, Jr., M.D.

22d. ADDRESS: Box 54 RD #2, Sykesville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2-13-67

23c. NAME OF CEMETERY OR CREMATORY: Wards Chapel Cemetery

23d. LOCATION (City, town or county) (State): Balto. Co. Md.

24. FUNERAL DIRECTOR ADDRESS: Harry W. Haight Sykesville, Md.

25a. REC'D BY REGISTRAR DATE: FEB 16 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02078

CERTIFICATE OF DEATH

02073

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 4mos. 13dys.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Baltimore County
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Randallstown
d. STREET ADDRESS: 3808 Courtleigh Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: AUGUST — Middle: JOHN — Last: SCHMITT

4. DATE OF DEATH: Month: FEBRUARY — Day: 6 — Year: 19 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ Sep.

8. DATE OF BIRTH: 8-8-1897

9. AGE (In years last birthday): 69 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Fireman (Retired)

10b. KIND OF BUSINESS OR INDUSTRY: Balto. Fire Dept.

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Frederick Schmitt

14. MOTHER'S MAIDEN NAME: Katherine Schmidt

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): Yes - Army, 1916-1919

16. SOCIAL SECURITY NO.: 218-26-3625

17. INFORMANT Address: Records, Springfield State Hospital

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Asystolism — INTERVAL BETWEEN ONSET AND DEATH: Seconds
DUE TO (b): Myocardial Infarction — 11 days
DUE TO (c): Arteriosclerotic Cardiovascular Dis — Years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Psychotic depressive reaction. CBS with cerebral arteriosclerosis, without qualifying phrase

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 9-23-66, 19__, to 2-6-67, 19__, that (I) (we) last saw the deceased alive on 2-6-67, 19__, and that death occurred at 3:00 A.M., from causes and on the date stated above.

22a. SIGNATURE: H. E. Connor M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 2-6-67

22c. PHYSICIAN'S NAME (Type): H. E. Connor, M. D.

22d. ADDRESS: Springfield State Hospital, Sykesville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2/9/67.

23c. NAME OF CEMETERY OR CREMATORY: Oaklawn Cemetery

23d. LOCATION (City or Town) (County) (State): Baltimore, Md.

24. FUNERAL DIRECTOR: Leonard J. Ruck, Inc. Balto. Md. 21214 — ADDRESS

25a. REC'D BY REGISTRAR DATE: FEB 8 1967

25b. REGISTRAR'S SIGNATURE: Charles Yaeger

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02079

CERTIFICATE OF DEATH

02074

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. **PLACE OF DEATH**
   a. COUNTY: Carroll — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
   c. LENGTH OF STAY IN 1b: 7mos.21dys.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): Springfield State Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Allegany
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
   d. STREET ADDRESS: 16 N. Lee Street
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First ANNE — Middle GERTRUDE — Last SHERRED

4. **DATE OF DEATH**: Month FEBRUARY — Doy 7 — Year 19 67

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 10-12-1891

9. AGE (In yeors last birthdoy): 75 yrs.
   IF UNDER 1 YEAR: Months — Doys
   IF UNDER 24 HRS.: Hours — Min.

10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & Stote, or foreign country): West Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Ross Webb

14. MOTHER'S MAIDEN NAME: Elizabeth (last name unk.)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
   (If yes give wor or dotes of service)

16. SOCIAL SECURITY NO.: 214-05-5869A

17. **INFORMANT** Address: Records, Springfield State Hospital

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (o), (b), ond (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (o): Carcinoma of esophagus — INTERVAL BETWEEN ONSET AND DEATH: Months
   DUE TO (b): Acute peritonitis due to superior mesenteric — Days
   Conditions, if ony, which gove rise to immediote couse (o), stoting the underlying couse lost.
   DUE TO (c): artery thrombosis

   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o): CBS assoc. with senile brain disease, without qualifying phrase

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20o. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Doy, Yeor Hour o.m. p.m. 19

20d. INJURY OCCURRED While ot work ☐ Not While ot work ☐

20e. PLACE OF INJURY (Home, form, foctory, street, office bldg., etc.)

20f. (City or town) (County) (Stote)

21. **I certify** that (I) (this haspital) attended the deceased from 6-16-66, 19__, to 2-7-67, 19__, that (I) (we) last saw the deceased alive an 2-7-67, 19__, and that death accurred at 8:15 AM, fram causes and an the date stated abave.

22o. SIGNATURE: Agustin del Campo. M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 2-7-67

22c. PHYSICIAN'S NAME (Type): Agustin del Campo, M. D.

22d. ADDRESS: Springfield State Hospital Sykesville, Maryland

23o. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2/10/67

23c. NAME OF CEMETERY OR CREMATORY: Sunset Memo. Park

23d. LOCATION (City or Town) (County) (Stote): Cumberland Md

24. FUNERAL DIRECTOR: Louis Stein Inc. — ADDRESS: Cumberland Md.

25o. REC'D BY REGISTRAR — DATE: FEB 14 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02080

CERTIFICATE OF DEATH

02075

1. PLACE OF DEATH
a. COUNTY: CARROLL — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): UNION BRIDGE
c. LENGTH OF STAY IN 1b: YEARS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): BROADWAY

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): UNION BRIDGE 06-1
d. STREET ADDRESS: BROADWAY
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First RUTH — Middle LAVINIA — Last SNYDER

4. DATE OF DEATH: Month FEB — Day 8 — Year 1967

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: SEPT 19 - 1899

9. AGE (In years last birthday): 67 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME

11. BIRTHPLACE (County & State, or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: FOSTER WAREHIME

14. MOTHER'S MAIDEN NAME: VINNIE BENEDICT

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO
(If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 218-46-0519

17. INFORMANT — Address: MRS OLIVIA HAY UNION BRIDGE MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Retroperitoneal Fibrosis — INTERVAL BETWEEN ONSET AND DEATH: about 1 year

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Radiation Therapy for carcinoma of the
~~DUE TO~~ (c): cervix — 1959

171X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour a.m. / p.m. — Month, Day, Year 19

20d. INJURY OCCURRED — While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1959 19..., to 2/8/67, 19..., that (I) (we) last saw the deceased alive on 2/7/67 19..., and that death occurred at 12:35 A M, from the causes and on the date stated above.

22a. SIGNATURE: J H Caricofe M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 2/8/67

22c. PHYSICIAN'S NAME (Type): J H CARICOFE
22d. ADDRESS: UNION BRIDGE MD

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 2/11/67
23c. NAME OF CEMETERY OR CREMATORY: MT VIEW
23d. LOCATION (City, town or county) (State): UNION BRIDGE MD

24 FUNERAL DIRECTOR'S SIGNATURE: D D Hartzler & Sons — ADDRESS: Union Bridge

25a. REC'D BY REGISTRAR DATE: FEB 10 1967
25b. REGISTRAR'S SIGNATURE: J Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 7-62

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02081

CERTIFICATE OF DEATH

02076

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. **PLACE OF DEATH**
   a. COUNTY: Carroll — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WESTMINSTER
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Carroll Co. General Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Frederick
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Brunswick
   d. STREET ADDRESS: Rosemont
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First LILLIE — Middle SHAW — Last WALTZ

4. **DATE OF DEATH**: Month 2 — Day 7 — Year 1967

5. SEX: F.

6. COLOR OR RACE: W.

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 9/15/87

9. AGE (In years last birthday): 79 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Shaw

14. MOTHER'S MAIDEN NAME: Myra Forrest

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 216-46-0524

17. INFORMANT: Mrs. Murial Kable — Address: Westminster Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): CARCINOMA OF RIGHT LUNG
   DUE TO (b): WITH DISTANT METASTASES
   DUE TO (c):
   Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
   163X
   INTERVAL BETWEEN ONSET AND DEATH: YEARS

   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): CEREBRAL VASCULAR INSUFFICIENCY

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from 2/6, 1967, to 2/7, 1967, that (I) (we) last saw the deceased alive on 2/7 1967, and that death occurred at 9:35 M, from causes and on the date stated above.

22a. SIGNATURE: Vincent J. Fusco Jr. M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2/7/67

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2/11/67

23c. NAME OF CEMETERY OR CREMATORY: Mount Olivet Cemetery

23d. LOCATION (City or Town) (County) (State): Frederick Maryland

24. FUNERAL DIRECTOR: Feete Funeral Home — ADDRESS: Brunswick Md.

25a. REC'D BY REGISTRAR DATE: FEB 14 1967

25b. REGISTRAR'S SIGNATURE: Charles Judy

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02082 02077

1. PLACE OF DEATH
a. COUNTY: CARROLL COUNTY MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): (RURAL) FINKSBURG, MD.
c. LENGTH OF STAY IN 1b: 4YRS.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 227A BETHEL ROAD

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: CARROLL
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): (RURAL) FINKSBURG, MD 06-1
d. STREET ADDRESS: 227A BETHEL ROAD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First GLADYS Middle MAE Last WAREHEIM
4. DATE OF DEATH: Month FEB Day 2 Year 1967

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: MAY 22, 1899
9. AGE (In years last birthday): 67 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: HOME
11. BIRTHPLACE (County & State, or foreign country): CAMBRIDGE, MD.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOSEPH F. FOY
14. MOTHER'S MAIDEN NAME: WINIFRED WROTEN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): —
16. SOCIAL SECURITY NO.: 213-36-8086B
17. INFORMANT: REV. KARL WAREHEIM Address: 227A BETHEL RD, FINKSBURG, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: hrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Hypertension + arteriosclerosis — years
DUE TO (c):

4670

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hypertrophic arthritis Senile

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1-1-1960, to 2-2-1967, that (I) (we) last saw the deceased alive on 1-28-1967, and that death occurred at 7:30 M, from the causes and on the date stated above.

22a. SIGNATURE: James G. Saffell M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 2-3-67
22c. PHYSICIAN'S NAME (Type): JAMES G. SAFFELL MD.
22d. ADDRESS: 64 MAIN ST. REISTERSTOWN, MD

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: FEB. 6, 1967
23c. NAME OF CEMETERY OR CREMATORY: SANDYMOUNT CEM.
23d. LOCATION (City, town or county) (State): SANDYMOUNT CARROLL, MD

24. FUNERAL DIRECTOR: James G. Saffell Jr. ADDRESS: 254 E. MAIN ST, WESTMINSTER, MD
25a. REC'D BY REGISTRAR DATE: FEB 6 1967
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02083

CERTIFICATE OF DEATH

02078

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. **PLACE OF DEATH**
   a. COUNTY: Carroll — MARYLAND
   b. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town): Westminster
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Carroll County General Hospt.

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Md. — b. COUNTY: Balto.
   c. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town): Reisterstown
   d. STREET ADDRESS: Old Hanover Road
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Marion — Middle: S. — Last: Welsh

4. **DATE OF DEATH**: Month: 2 — Day: 18 — Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept. 22, 1895

9. AGE (In years last birthday): 71 yrs.
   IF UNDER 1 YEAR: Months: — Days: —
   IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Balto. City

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Edward E. Lewis

14. MOTHER'S MAIDEN NAME: Ella J. Rhoten

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
   (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 220-48-5226

17. INFORMANT — Address: Mr. A. Earl Welsh Reisterstown, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): ACUTE DIAPHRAGMATIC + LATERAL
   DUE TO (b): MYOCARDIAL INFARCTION
   Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
   DUE TO (c):
   INTERVAL BETWEEN ONSET AND DEATH: HOURS

   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 2/18, 1967, to ____, 19__, that (I) (we) last saw the deceased alive on 2/18 1967, and that death occurred at 6:40 M, from causes and on the date stated above.

22a. SIGNATURE: Vincent J. Fiocco Jr — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2/18/67

22c. PHYSICIAN'S NAME (Type):

22d. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 2/22/67

23c. NAME OF CEMETERY OR CREMATORY: Evergreen Memorial

23d. LOCATION (City or Town) (County) (State): Finksburg, Md.

24. FUNERAL DIRECTOR — ADDRESS: J. F. Eline & Sons Reisterstown, Md.

25a. REC'D BY REGISTRAR — DATE: FEB 21 1967

25b. REGISTRAR'S SIGNATURE: J. Charles Jones

1

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02084

CERTIFICATE OF DEATH

02079

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH a. COUNTY: Carroll	2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE: Maryland b. COUNTY: Baltimore
b. CITY OR TOWN (If outside carparate limits, write RURAL and give nearest tawn): Sykesville	c. LENGTH OF STAY IN 1b: 25yrs.-5mons.
c. CITY OR TOWN (If outside carparate limits, write RURAL and give nearest town): Baltimore 30.4
d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give street address): Springfield State Hospital	d. STREET ADDRESS: Windsor Court Apartments e. IS RESIDENCE ON A FARM? YES ☐ NO ☒
3. NAME OF DECEASED (Type or print): First Edward Middle Milton Last WIMMER	4. DATE OF DEATH: Month 2 Day 12 Year 1967
5. SEX: Male	6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ sep.	8. DATE OF BIRTH: 8-25-1884
9. AGE (In years last birthday): 82 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Haurs Min.
10a. USUAL OCCUPATION (Give kind of wark done during mast of working life, even if retired): Solicitor	10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (County & State, or foreign country): Germany Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Edward M. Wimmer	14. MOTHER'S MAIDEN NAME: Elizabeth Wolk
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): unknown (If yes give war or dates of service)	16. SOCIAL SECURITY NO.: 215-07-9231
17. INFORMANT (Name, relationship, or title) Wm. Hayes Address: 2819 Green Lawn Dr. Hospital Records

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter anly one cause per line far (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Massive Hemarrhage both lungs — INTERVAL BETWEEN ONSET AND DEATH: Hrs or days

DUE TO

Conditions, if ony, which gave rise to immediate cause (a), stating the underlying cause last. 4621

(b): Bleeding Varices + Ulcer of Esophagus — Hrs or days

DUE TO

(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Haur a.m. p.m. 19	20d. INJURY OCCURRED While at work ☐ Nat While at work ☐	20e. PLACE OF INJURY (Hame, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 9-9, 1941, to 2-12, 1967, that (I) (we) last saw the deceased alive an 2-12 1967, and that death occurred at 1:45 P.M, from couses and on the date stated above.

22a. SIGNATURE: R. G. Lajonchere MD M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐		22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): R. G. LAJONCHERE MD	22d. ADDRESS	

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE THEREOF: 2-14-67	23c. NAME OF CEMETERY OR CREMATORY: Loudon Park Cemetery	23d. LOCATION (City or Town) (County) (State): Baltimore, Md	
24. FUNERAL DIRECTOR: Ellsworth, Armacost	ADDRESS: 4600 Liberty Hghts. Ave.	25a. RECD BY REGISTRAR DATE: FEB 14 1967	25b. REGISTRAR'S SIGNATURE: J. Charles Judge	

2111 Harrison Blvd

1 (M)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02085

CERTIFICATE OF DEATH

02080

1. PLACE OF DEATH
   a. COUNTY: Carroll — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Westminster
   c. LENGTH OF STAY IN 1b: Life
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): Carroll County General

2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before odmission)
   a. STATE: Maryland — b. COUNTY: Baltimore
   c. CITY OR TOWN (If outside carparate limits, write RURAL and give neorest town): Monkton
   d. STREET ADDRESS: Rt 2 York Rd
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Wallace — Middle: Garfield — Lost: Wolf

4. DATE OF DEATH: Month: 2 — Doy: 27 — Year: 1967

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 2/24/67

9. AGE (In yeors lost birthdoy) yrs.

IF UNDER 1 YEAR: Months — Days: 3 — IF UNDER 24 HRS.: Hours — Min.: 8

10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & Stote, or foreign country): Carroll Co. Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Wallace

14. MOTHER'S MAIDEN NAME: Faye Woodward

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wor or dotes of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Wallace Wolf, Sr. — Address

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (o), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): Prematurity B. W 2.14" — INTERVAL BETWEEN ONSET AND DEATH
776X
DUE TO
Conditions, if ony, which gove rise to immediote couse (o), stoting the underlying couse lost.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(o)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20o. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Doy, Year Hour o.m. p.m. 19

20d. INJURY OCCURRED While ot work ☐ Not While ot work ☐

20e. PLACE OF INJURY (Home, form, foctory, street, office bldg., etc.)

20f. (City or town) (County) (Stote)

21. **I certify** that (I) (this haspital) attended the deceased from 2-24, 1967, to 2/27, 1967 that (I) (was) last saw the deceased alive on 2-27 1967, and that death accurred at 9:00 A M, from causes ond on the date stoted above.

22o. SIGNATURE: Karl M Green M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2-27-66

22c. PHYSICIAN'S NAME (Type): Karl M. Green, M.D.

22d. ADDRESS: Westminster, Maryland

23o. BURIAL, CREMATION, REMOVAL (Specify): Carroll Co. Hosp.

23b. DATE THEREOF: 2-27-67

23c. NAME OF CEMETERY OR CREMATORY: Carroll Co. Gen. Hosp.

23d. LOCATION (City or Town) (County) (Stote): Westminster, Car., Md.

24. FUNERAL DIRECTOR Glenn R. Fisher ADDRESS: Glenn R. Fisher, Administrator, Carroll County General Hospital

25o. REC'D BY REGISTRAR DATE: MAR 3 1967

25b. REGISTRAR'S SIGNATURE: Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02086

CERTIFICATE OF DEATH

02081

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Manchester, md 128 W main ST
c. LENGTH OF STAY IN 1b: 9 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Longview Nursing Home Inc. 128 W. main ST

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Finksburg, md.
d. STREET ADDRESS: Route #1.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Grace — Middle: E. — Last: Yingling

4. DATE OF DEATH: Month: February — Day: 19 — Year: 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 20, 1892

9. AGE (In years last birthday): 74 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeping

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Silver Park Carroll Co.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Yingling

14. MOTHER'S MAIDEN NAME: Laura Bush.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 220-26-2305

17. INFORMANT: John Yingling — Address: Finksburg md Route #1.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 163X
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.
DUE TO (b): Carcinoma of Rt Lung
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH: (?)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from February 10, 1967, to February 19, 1967, that (I) (we) last saw the deceased alive on February 19 1967, and that death occurred at 11 P M, from the causes and on the date stated above.

22a. SIGNATURE: Joseph E Bush M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 2-19-67

22c. PHYSICIAN'S NAME (Type): Joseph E Bush MD

22d. ADDRESS: Hampstead Maryland

23a. BURIAL, ~~CREMATION~~, ~~REMOVAL~~ (Specify): Burial

23b. DATE THEREOF: 2-22-67

23c. NAME OF CEMETERY OR CREMATORY: Sandymount Cemetery

23d. LOCATION (City, town or County) (State): Finksburg RD Md.

24. FUNERAL DIRECTOR — ADDRESS: Robert Kyle Butler Jr. 44 Longwell Ave Westminster, Md.

25a. REC'D BY REGISTRAR — DATE: FEB 23 1967

25b. REGISTRAR'S SIGNATURE: J Charles Judge

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02087

CERTIFICATE OF DEATH

02082

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. **PLACE OF DEATH**
   a. COUNTY: Carroll — MARYLAND
   b. CITY OR TOWN (If outside corparate limits, write RURAL and give nearest tawn): Westminster
   c. LENGTH OF STAY IN 1b: Life
   d. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital, give street address): Carroll County General

2. **USUAL RESIDENCE** (Where deceased lived, if institutian: Residence before admissian)
   a. STATE: Maryland — b. COUNTY: Carroll
   c. CITY OR TOWN (If outside corparate limits, write RURAL and give nearest tawn): Westminster — 06-1
   d. STREET ADDRESS: 225 Green Wood Ave
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Denise — Middle: MARIA — Last: ZenTz

4. **DATE OF DEATH**: Manth: 2 — Day: 1 — Year: 1967

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 12-8-66

9. AGE (In years last birthday) yrs.

IF UNDER 1 YEAR: Months / Days 23 — IF UNDER 24 HRS.: Haurs / Min.

10a. USUAL OCCUPATION (Give kind of wark dane during mast af warking life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (Caunty & State, ar fareign cauntry): Carroll County

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Vimmy ZenTz

14. MOTHER'S MAIDEN NAME: Dorothy ZenTz

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na, ar unknawn) (If yes give war ar dates af service)

16. SOCIAL SECURITY NO.

17. **INFORMANT** Address: Jimmy ZenTz

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter anly ane cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 12 hours
DUE TO (b): Myocarditis — ? 2wks
Conditians, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):
4-22-2

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Bronchial pneumonia

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature af injury in Part I ar Part II af item 18.)

20c. TIME OF INJURY Manth, Day, Year Haur a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Nat While at work ☐

20e. PLACE OF INJURY (Hame, farm, factary, street, affice bldg., etc.)

20f. (City ar tawn) (Caunty) (State)

21. **I certify** that (I) (~~this haspital~~) attended the deceased from 1-31, 1967, to 2-1, 1967, that (I) (we) last saw the deceased alive an 1-31 1967, and that death occurred at 1A M, from causes and on the date stated above.

22a. SIGNATURE: Karl M Green M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 2/1/67

22c. PHYSICIAN'S NAME (Type): KARL M. GREEN — 22d. ADDRESS: WESTMINSTER, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL — 23b. DATE THEREOF: 2/3/67 — 23c. NAME OF CEMETERY OR CREMATORY: WESTMINSTER CEMETERY — 23d. LOCATION (City ar Tawn) (Caunty) (State): WESTMINSTER, MD.

24. FUNERAL DIRECTOR ADDRESS: J. S. Myers, Jr., Westminster, Md.

25a. REC'D BY REGISTRAR DATE: FEB 3 1967 — 25b. REGISTRAR'S SIGNATURE: J Charles Judge

6-193641